

**A SOCIOLOGICAL ANALYSIS OF  
PROFESSIONALISATION OF  
ORTHODOX AND ALTERNATIVE  
MEDICINE IN RUSSIA**

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## ABSTRACT

This thesis provides a sociological analysis of orthodox medical and alternative practitioners in contemporary Russia. It explores the social and economic position of orthodox medical practitioners and the potential for professionalisation using a Neo-Weberian perspective. It also examines the relationship between alternative and orthodox medical practitioners, their professional standing and current organisation. A model for assessing the economic and power resources of Russian doctors in the past and in contemporary Russia is developed to assess their strategies for professionalisation. Data for the study comes from three sources: first, a historical analysis of both orthodox and alternative medicine in Russia; second, data drawn from a European/Russian funded project of a large sample of medical practitioners in three Russian regions and third, semi-structured interviews undertaken with 39 orthodox and alternative medical practitioners. The research found that Russian medical practitioners are discontented with their professional standing and strive to redefine it, although they lack economic and power resources. State and private doctors differ in their aims and strategies for professionalisation. State doctors do not trust professional associations. They look to state action to enhance their social and professional standing. In contrast, Russian private doctors rely more on professional associations and push for self-regulation. There was no observable antagonism by Russian rank-and-file doctors towards alternative medicine. This may be because many medical doctors have additional qualifications in alternative medicine. The state still marginalises alternative medicine in terms of funding and support. However, most alternative practitioners strive for equal status with orthodox medicine through professional associations which aim to be fully integrated into the state health care. A minority have built a private client base, support professional associations which seek self-regulatory powers and have voluntary registers.



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# INTRODUCTION

The introductory chapter first explains the focus and rationale of this research and outlines the main propositions to be investigated. Second, it provides an overview of the theoretical starting point and the main methods for the data collection of research and identifies the independent contribution of the author in a larger project taken as a basis of the research. Third, the key definitions used to establish positions taken in the thesis are discussed. A major problem that had to be addressed in undertaking the thesis is that the definitions adopted by Anglo-American and Russian social researchers are often not uniform, so key and controversial terms are defined here. Fourth, the introduction gives a brief overview of the structure and content of the chapters that follow.

## 1. The focus of the thesis

This thesis provides a sociological analysis of orthodox medical and alternative practitioners in contemporary Russia. It draws on a number of areas of empirical research and has two main aims. First, it aims to assess the social and economic position of orthodox medical practitioners in contemporary Russia in order to explore the potential for professionalisation – a concept drawn from the Anglo-American sociology of the professions. Second, it aims to explore the relationship between alternative and orthodox medical practitioners – again in terms of their professional standing and current organisation.

The thesis makes an original contribution to knowledge in a number of ways:

First, a major research problem was theoretical. In Russian sociology, the ‘professions’ have been conceptualised and investigated in different ways from the Anglo-American tradition, therefore a major issue was how this body of literature could be applied in the Russian context. The Western sociology of the professions had limited relevance to Russia in the Soviet period because, as a socialist state, it operated closer to a state centrist or command economy model without legally-defined professional monopolies. However, with a major political change away from socialism over the past decade and a



half, Russian society has become more market-oriented, with increasing opportunities to build professional enclaves.

The thesis develops an original conceptual framework for analysing the professional standing of orthodox and alternative medical practitioners based on the Anglo-American literature (Abbott 1988; Larson 1990; Johnson *et al.* 1995; Macdonald 1995; Freidson 2001). The framework has been used for analysing selected data in a larger research project, the INTAS study, where data were collected from a large sample of medical practitioners in three Russian regions. The author was a senior researcher on this study. The framework has also been applied to study the current status of alternative practitioners and their relations with orthodox medical practitioners in a small-scale intensive study in Moscow. Such a theoretical framework has not been developed and applied before in Russia.

Second, the timing of the research provided an opportunity for another original contribution. The thesis makes up for the lack of research on the changes in the social standing of Russian orthodox and alternative practitioners and their potential for professionalisation at a period of current socio-economic reform. The research was undertaken in a Russia in transition, when the political changes and the subsequent trend towards the market have opened up new opportunities for professionalisation of Russian orthodox and alternative practitioners. However, the dynamics in social position and professional standing of orthodox medical and alternative practitioners have been largely ignored by Russian social researchers. The INTAS project and the empirical work undertaken offer a wealth of original material relating to the theme of the thesis.

Third, another original aspect of the thesis is the focus on alternative as well as orthodox practitioners. There has been almost no work on alternative health practitioners within Russia. To fill a gap in the research, the thesis will incorporate Anglo-American theoretical insights in the field of alternative medicine (Sharma 1995; Fulder 1996; Kelner *et al.* 2000; Saks 2003a). This thesis aims at providing a balanced account of the development of health care in Russia considering both orthodox and alternative medicine on equal terms. This is in contrast to one-sided narratives, which focus on either orthodox or alternative medicine, in some cases as if the two were entirely separate spheres. The thesis studies the response of orthodox medical



practitioners and the state to the rise of alternative medicine, and examines the social standing of alternative medical practitioners in terms of status, income and power.

Fourth, the thesis can be considered an original piece of research as it shows the historical development of medical profession and alternative practice in Russia, in comparison to Britain and other Western countries. The thesis overviews how these differences have been shaped; what factors historically have supported the professionalisation process of Russian orthodox and alternative practitioners and those factors that have hindered the process. However, it should be noted that the references to the development of Western medical professionals have been selected only in so far as the differences or similarities were apparent in relation to the Russian history.

## **2. The independent contribution of the author**

A background to the thesis was provided by an INTAS-funded project *Russian Doctors: Social Attitudes and Strategies for Adaptation* conducted by the Institute of Sociology of the Russian Academy of Sciences in Moscow and the Faculty of Health and Community Studies at De Montfort University in Leicester, in consultation with the Institute of Occupational Health in Helsinki. This project focused on the status of orthodox medical practitioners, their values and social attitudes. The INTAS-project was conducted by the joint team of researchers, including Professor Allsop (De Montfort University, UK), Professor Saks (Lincoln University, UK), and Dr Kauppinen (the Institute of Occupational Health, Finland), who helped the Russian team of Professor Mansurov and senior researcher Luksha<sup>1</sup> to develop the questionnaire design and, in the subsequent data analysis, to draw on a theoretical framework developed from the Anglo-American sociology of professions and social stratification theory.

For this INTAS project, the author carried out independent research in Komi region, one of the three regions chosen for the survey. The field work in Komi region had the following components: (1) questionnaire survey of 149 respondents who filled in self-administered questionnaires; (2) twenty in-depth interviews with head doctors and head of departments in Komi region (in detail see Chapter IV). The interviews were

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<sup>1</sup> The Russian team also included: Dr Plotnikov, senior researcher Epihina and researcher Zobina (their responsibilities are described in detail in Chapter IV Methods and Methodology).



transcribed verbatim. The author also participated on a par with other Russian researchers in the process of producing frequency tables and cross-tabulations with the aid of SPSS, and analysing the data. During the research the author analysed empirical material and wrote the early first drafts of a number of conference papers and publications, which were substantially revised and enlarged by Professors Allsop, Mansurov, and Saks. The list of papers arising from the thesis are shown in Appendix 1.

The quantitative data from the INTAS research also helped to contextualise the small scale, intensive study of alternative practitioners in Moscow carried out by the author. The data from the INTAS research served to provide an understanding of the scope of alternative practice undertaken by orthodox practitioners, their referral patterns to alternative practitioners and their attitude towards the integration of alternative medicine into the state sector. However, the information had to be informed by qualitative data to become broader and well-rounded. The author selected ‘purposefully’ alternative practitioners who could best answer the research questions. Nineteen prominent alternative practitioners were interviewed, including heads and deputy heads of eight large professional associations and renowned rank-and-file members of these associations.

### 3. Definitions

The definitions adopted by Anglo-American and Russian social researchers are often not uniform, so key and controversial terms are defined more fully below to establish positions taken in the thesis. Most problems with the applicability of Anglo-American terminology and definitions emerge as a consequence of the differences in the history and organisational structures within which Russian and Western orthodox and alternative medical practitioners work. The major difference is that in Russia, the state medical bureaucracy is the sole regulator and carries out *all the regulation* in the health care sector, whereas professional associations mainly combine the functions of trade-unions and ‘learned societies’ (Burrage *et al.* 1990) oriented towards dissemination of scientific knowledge. Alternative medicine is also tightly regulated by the state. Neither orthodox nor alternative practitioners exercise the right to determine their remuneration and to make independent policy decisions as the legitimate experts on health matters.



In addition, there are formal restrictions imposed on the practice of alternative medicine in Russia, as in most states of the European Union – in that ‘alternative’ practice is illegal except by statutorily recognised health professionals (State Duma 1993a). Only one group of lay practitioners has been allowed to practise, namely those who were officially termed ‘folk healers’ who could prove that they had a special gift for healing or that their knowledge in traditional medicine such as bone-setting, herbalism or hydrotherapy was inherited from their ancestors (State Duma of the Russian Federation 1993b). There has been tolerance towards accepting these folk therapies for cultural and historical reasons (Figes 2003). As a result, all professional associations of alternative practitioners consist of medically qualified doctors, with the exception of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers whose members have a gift in folk traditional medicine. The impact of these structural differences on definitions used in the thesis is shown below:

1. The concept of ‘profession’ in Russian sociology, and in the Russian language, is associated with all crafts and skilled occupations. There has never been a parallel meaning to the concept as used in Western countries, in which a group deemed to be ‘professional’ can define a boundary between itself and the outside world. In the thesis, this problem was solved by working out a definition of ‘profession’ which does not imply self-regulatory powers and a high social status in the labour force. ‘Profession’ will therefore be defined in the thesis as:

a knowledge-based occupation requiring higher specialised education, which has a jurisdictional control over a body of knowledge and its application, such that an occupational group may translate its scarce cognitive resources into economic and social rewards.

The definition is intended for use in cross-cultural research.

2. The author was not able to identify any published studies by Russian social researchers, which used the term ‘professionalisation’, – whereas many up-to-date definitions of ‘professionalisation’ in the Anglo-American sociology of professions were inappropriate to the Russian context. As already discussed, Russian doctors differ from their Western colleagues in that they do not have an exclusive jurisdiction in a particular division of labour created and controlled by occupational negotiation (Freidson 2001: 127). Further, they do not have a sheltered position in both external and



internal labour markets that is based on qualifying credentials created by the occupation. These attributes are taken as significant elements of the professionalisation process of medical practitioners in many Anglo-American definitions. Within the context of Russia, where the market is still at an early stage of formation and where state regulation is strong, the following definition of professionalisation is suggested. 'Professionalisation' will be defined in the thesis as:

The drive of professionals for the enhancement of the scope of power, and gaining economic or cultural resources in the market place or exercising influence within the state sector, in order to achieve legally underwritten professional monopoly.

3. Anglo-American categories of 'orthodox' and 'alternative' medicine can be used in Russia, but there are limits, as most alternative practitioners are medically qualified doctors. In the thesis, orthodox medicine has been defined as including all forms of health care that have significant support of the state (Saks 2003a: 3). Alternative medicine is taken to refer to all therapies that are found outside the medical mainstream and are marginalised by orthodox practitioners in relation to research undertaken and inclusion in education and training programmes for orthodox health professionals (Saks 2003a: 4). The issues of Anglo-American terminology and its modification for cross-cultural research are considered fully in Chapters I and II of the thesis. These issues were also taken into consideration in the methodology and research design.

## **4. The structure of the thesis**

This section helps to provide an overview of the thesis. Each chapter is briefly described as follows:

**Chapter I Professions and Professionalisation: Main Theories and Definitions** sets the scene for the thesis by outlining the mainstream concepts of the classic theories of professions. This chapter provides a critical analysis of the most widely used definitions of the terms 'profession' and 'professionalisation' to develop the theoretical direction of research for the thesis. It is argued that the Anglo-American social scientific literature has ignored professional groups in Europe, whereas 'professions' and

‘professionalisation’ might be conceived as universally recognisable social formations which have some differences and some similarities in various industrialised countries.

**Chapter II Orthodox and Alternative Medicine: the Issue of Terminology and the Characteristics of the Main Alternative Therapies** explores the definitions of orthodox and alternative medicine in Western countries and in Russia in order to elaborate the definitions of medicine which will be used in the thesis. These definitions are analysed in terms of the approaches of orthodox and alternative medical practitioners to treatment and in terms of their position in the wider social context. Here, particular emphasis is placed on alternative medicine, as orthodox medicine had been discussed in the previous chapter. This chapter also provides a glossary and short history of the main alternative therapies currently used in Russia.

**Chapter III A Historical Analysis of the Development of Medicine in Russia** aims to provide a balanced account of the development of health care in Russia that considers both orthodox and alternative medicine on equal terms. It examines both sides of the health care coin from a neo-Weberian perspective with a particular emphasis on the theme of professionalisation. The period taken for analysis is broad, starting from the formation of the Russian state, and concluding in the 1990s with the demise of the Soviet power. The chapter provides the background for understanding of the historical and current state of regulations in medicine and of medical professionalism in Russia.

**Chapter IV Methodology and Methods** provides the link between research questions posed in the previous chapters and the methods of data collection and analysis. It covers the first stage of the research which considers the professionalisation tendencies of orthodox practitioners, drawing on the INTAS-funded research project *Russian Doctors: Social Attitudes and Strategies for Adaptation*. It also describes the second stage of the research oriented towards the study of alternative practitioners based on interviews with alternative practitioners. The chapter seeks to assure readers that data collection and analysis have been reflexive and rigorous.

**Chapter V The Professionalisation of Orthodox Medical Practitioners in Russia in Transition: Process and Perspectives.** The main purpose of this chapter is to consider whether the changes in the social standing of the physicians and social status of the medical profession have occurred since the beginning of the 1990s reforms. It also



describes new trends in the professionalisation of the medical profession in Russia, arguing that there are signs of a resurgence of professional associations and a corporate drive from doctors to redefine their rights and obligations. It is also suggested that professionalisation tendencies are oriented towards enhancing the social standing of medical practitioners, albeit in a minor way.

**Chapter VI The State Regulation of Alternative Medicine and the Response of Orthodox Practitioners to Alternative Medicine** considers the response of the Russian state and the orthodox medical profession towards alternative approaches in medicine. It investigates the scope of knowledge of, and interest in, alternative medicine among Russian orthodox doctors, drawing on data from the INTAS research. It examines the views of conventional doctors on the validity of alternative medicine in terms of whether they referred their patients to alternative practitioners and to what extent they were ready for the wider integration of alternative medicine into the state sector.

**Chapter VII The Professionalisation of Alternative Medicine in Russia in Transition: Process and Perspectives** focuses on the efforts of alternative practitioners to redefine their social standing, which is still marginal in the Russian health care sector. The professional organisations of statutorily recognised alternative practitioners who provide their services full-time in the state or private health care sector are brought into focus here. The chapter provides the numbers of Russian alternative practitioners and the scope of their membership in professional organisations. It also describes the current social standing of all major professional organisations of alternative practitioners and explores what aspirations their leaders hold for the future.

**Conclusion** outlines the main findings of the research problem and the opportunities for further investigation. It also comments on the implications of the thesis for theory development and for health policy.

# **I. PROFESSIONS AND PROFESSIONALISATION: MAIN THEORIES AND DEFINITIONS**

This chapter will set the scene for the thesis by outlining the mainstream concepts of the classic theories of professions. The aim is to adapt Anglo-American theoretical models to the Russian reality. As argued in the Introduction, these theories had limited relevance to Russia in the Soviet period because, as a socialist state, it operated closer to a state centrist or command economy model without legally defined professional monopolies (Lane 1985). However, with a major political change away from socialism over the past decade and a half, Russian society has become more market-oriented, thus increasing opportunities to build professional enclaves. The result of this is that – whilst there are still significant differences in the standing and autonomy of professions in Russia – there has been growing interest in the application of neo-Weberian and other predominant Anglo-American models to understanding developments in Russia (Mansurov *et al.* 2004).

This chapter traces the chronology of the usage of the concepts of ‘profession’ and ‘professionalisation’ in the Anglo-American social science literature in order to provide a critical analysis of the most widely used definitions of the terms and to develop the theoretical direction of the thesis. The first part describes the early period of formation of the sociology of professions and its ‘golden age’ in the era during the predominance of structural functionalism. At that early stage, ‘trait’ and functionalist approaches were the most popular. These approaches regarded professional groups as different from other occupations in that they played an important and positive part in society. The second part begins with a critical reinterpretation of the concepts of ‘profession’ and ‘professionalisation’ by Marxist and neo-Weberian researchers, which centred on the relations of production and the market respectively. It then shows that the ascendancy of neo-Weberians – with their focus on monopolies based on exclusionary social closure – has recently been complemented by the work of Foucauldian and other social researchers, who breathed new life into the study of professions (Allsop and Saks 2000). The third part of the chapter discusses the applicability of mainstream Anglo-American enquires into the nature and social standing of the ‘professions’ to continental European professions. It argues that the Anglo-American social scientific literature has ignored professional groups in Europe. ‘Profession’ and ‘professionalisation’ might be



conceived as universally recognisable social formations which have some differences and some similarities in various industrialised countries.

The tradition of the study of professions goes back to Durkheim, who laid emphasis on the importance of professional ethics in his book *The Division of Labour in Society* in 1893 (Durkheim 1933). In the Anglo-American social tradition, Flexner was the first social researcher preoccupied with the question of which occupations should be called professions and by what criteria (Flexner 1915). Since then, the search for the nature of the concept of the profession and the professionalisation has ended up in the growth of a great number of contradictory definitions, as Burrage argues 'there can be few areas of social enquiry that have become so involved, distracted and perplexed by matters of definition than the study of the professions' (Burrage *et al.* 1990: 204). The following review of the theoretical work on 'professions' and 'professionalisation' aims at searching for the strengths and weaknesses of different definitions starting from the functionalist approaches and progressing to the more action-based theoretical approaches.

## **1. The trait and functionalist approach: defining 'profession' and 'professionalisation'**

### **1.1. The trait and functionalist approach: defining 'profession'**

Research in the sociology of professions began with the attempts to differentiate between the high-status socially idealised occupations based on a higher education. Social scientists chose as an object of their research the occupations that traditionally enjoyed the prestigious title of the 'profession', – law, medicine, divinity and university teaching (Dingwall and Lewis 1983: 10). These professional groups have had a high prestige and autonomy and above average social-economic remuneration. And the earliest writings on the professions created definitions which were reflections of the peculiar historical development of the occupations especially distinguished from others within the social structure of the Anglo-American society (Freidson 2001). The first social research addressed the issues of what characteristics, other than higher education alone, these professional groups had in common that led to their higher social standing.



The so-called 'trait writers' did not try to draw a social portrait of the conventional professions such as law and medicine. Rather, they were in quest of the 'nature' or 'essence' of the phenomenon, which, they thought, could be captured through a set of discriminating criteria, inherent in all the conventional professions (Dingwall and Lewis 1983: 12). On the basis of these criteria or variables social scientists tried to construct an 'ideal type' of what constituted the profession (Weber 1949). The trait writers used the concepts 'ideal type of the profession' and 'the profession' interchangeably. Their aim was to develop an ideal type of what constituted a profession based on observed social characteristics of professions. However, in identifying particular characteristics and linking them, they inevitably reified the ideal type, in the sense of regarding this abstract concept as if it were a concrete thing (Berger and Luckmann 1966).

Occupations that were deprived of the 'professional' status were viewed by trait writers from the perspective that they needed to 'professionalise', to approximate to the ideal model of the profession (Carr-Saunders and Wilson 1933). Some social researchers introduced the concept of a 'continuum of professionalism' – that is, an idea that all occupations vary from fully-fledged professions to those occupations, which possess attributes characterising the professions to a lesser degree. Thus, the concepts of 'semi-profession', 'new profession', and 'would-be-profession' were developed (Etzioni 1969). For example, Carr-Saunders suggested a similar classification, where he measures the degree of the approximation of different occupations to the ideal-type profession according to their type of knowledge-base. He singled out four major types of professional occupations in society (Carr-Saunders 1955: 279-87): (1) the established professions (law, medicine and the Church; (2) the new professions (engineering, chemistry, accounting and the natural and social sciences); (3) the semi-professions (nursing, pharmacy, optometry and social work); (4) the would-be professions (managers and business administrators).

As a result of the fact that specific historical professional groups were taken as a starting-point of the research, American and English trait writers managed to reach a degree of consensus on the problem of the differentiating characteristics of the 'profession' and 'professionals'. In a classic study of the sociology of professions Goode writes: 'If one extracts from the most commonly cited definitions all the items which characterise a profession ... a commendable unanimity is disclosed: there are no contradictions and the only differences are those of omission' (Goode 1960: 910).



Millerson developed one of the fullest collections of the 'professional' indicators composed of twenty-three variables (Millerson 1964). Other social scientists rejected the idea of listing exhaustive criteria for distinguishing professions from the occupations; instead, they tried to work out integrative categories, in which separate indicators could fall as 'subsets' (Pavalko 1972: 80). Saks (1999a) suggests that mostly these 'check-lists' of integrative categories consisted of theoretically unrelated attributes. However, a brief review of the most frequently cited characteristics of the profession will provide a better understanding of the origin of the contemporary debates in the field of the sociology of the professions.

The search for the ideal model of the profession fits into the paradigm of functionalism, although some trait writers did not associate themselves with functionalism. However, in the late 1950s, the functional approach to sociology became so dominant that the discipline of sociology and functionalism became more or less identical (Wallace and Wolf 1995: 17). Functionalist analysis looks on social systems as having certain needs, and all society as a system of social structures (economic, legal, educational, gender structures) (Parsons 1951). These structures have been seen as functional in the sense that they help society to operate. Interconnections exist within, and among, these systems, and individuals and groups are constrained by them. Within this theoretical framework, Parsons saw the professions, for example, as a specific structure within the social system.

The key defining aspects of the ideal model of the profession mostly drew on the main concepts of functionalism and can be described as follows (Greenwood 1957; Goode 1960; Barber 1963; Millerson 1964; Parsons 1968):

- Professional expertise, the mastery of which is drawn from an ever developing and complex theoretical base and necessarily involves lengthy study and training. Authoritative professional advice, which clients follow without knowing why it is good advice.
- Professional altruism, a social good at which the expertise is directed. Allegiance is expressed through a pledge to follow a code of conduct.
- Professional autonomy in setting standards of practice, the content of education, entry into and exit from the profession.

The above-mentioned integrative categories, probably generated most of the other professional traits that were considered to be typical of the established professions. More recent work has not denied the importance of such traits, but has given greater emphasis to the strategies actively deployed to engender such a position (Cant and Sharma 1996a: 6). These integrative categories are considered further in more detail with the purpose of understanding which of them can be used in an adequate, coherent and useful definition of the profession.

### 1.1.1. Professional expertise

An ubiquitous assumption in writing on professions appeared to be that a profession should have an essential underpinning of abstract principles which have been organised into a theory or at least a complex set of theoretical orientations. Most influential sociologists of the time singled out this criterion as a key one (Greenwood 1957; Goode 1960; Parsons 1968). Parsons (1968: 545) wrote

‘boundaries of the group system we generally call the professions are fluid and indistinct... However, the core criteria within the more general category of occupational role seem to be relatively clear. First among these criteria is the requirement of formal technical training accompanied by some institutional mode of validating both the adequacy of the training and the competence of trained individuals. Among other things, the training must lead to some order of mastering of a generalised cultural tradition and do so in a manner giving prominence to an *intellectual* component – that is, it must give primacy to the valuation of cognitive rationality as applied to a particular field. The second criterion is that not only must the cultural tradition be mastered, in the sense of being understood, but skills in some form of its use must also be developed’.

The possession of specialised/expert knowledge was considered as monopolised by the members of the profession: ‘lay’ people were not fully competent to evaluate the knowledge and skills of ‘professionals’, although they must find the professional knowledge trust-worthy (Haug and Sussman 1969). Thus, public acceptance of professional authoritative advice was seen as crucial in determining whether an occupation could be called a profession. This idea was highlighted in Goode’s reasoning about professional knowledge. He suggested that a few characteristics of such knowledge affected the acceptance of an occupation as a profession (Goode 1969: 277):



the knowledge and skills should be abstract and organised in a codified body of principles. This knowledge should be applicable, or thought to be applicable, to the concrete problem of living. And the profession should be accepted as the final arbiter in any disputes over the validity of any technical solution lying within its area of supposed competence.

Another important characteristic of professional knowledge had to do with the fact that the profession itself should help create, organise and transmit knowledge. This assumption is congruent with Parsons's emphasis on the perpetuation and development of the knowledge base of professions (Parsons 1968: 546). Trait and functionalist writers wrote that a specific type of education was indispensable for constituting an ideal profession, namely education should be (1) prolonged and specialised in (2) a body of symbolic, abstract knowledge, which goes along with (3) mastering of a professional subculture, comprised of values, norms and concepts of the professional role (Greenwood 1957; Goode 1969). As Ben-David says 'It seems that professional subcultures and the rest of professional characteristics emerge on the basis of prolonged study and training in a certain field and can be maintained by research activity, professional literature, legislation, etc.' (Ben-David 1960: 825).

### **1.1.2. Professional altruism**

Following the functionalist and trait writers, professional competence had to correlate with the most important values of society. They argued that those work activities which have an immediate relation to the establishment and maintenance of the main values of the society, in a case they possess other required 'professional' characteristics, may be called professions (Barber 1963). Parsons claimed that 'a full-fledged profession must have some institutional means of making sure that such competence will be put to socially responsible uses' (Parsons 1968: 545). He argued that the most obvious 'socially responsible use' of professional knowledge was in the sphere of its application to medical science. At the same time, he mentioned that the skills of teaching and of research in the 'pure' intellectual disciplines – the humanities, and the natural and social sciences – could also be included in the sphere of professional activities. Most social researchers distinguished medicine (treatment of the body), divinity (salvation of the soul) and law (defence of the rights) (Dingwall and Lewis 1983).



Thus, professionals were seen as primarily disposed to serve the community, as opposed to self-interest. The technical solutions which the professionals arrived at, were conceived as based on the needs of clients, not on the material interest and needs of the professional (Goode 1969: 278). Thus, the system of moral and material remuneration was seen as a fair reward of the profession by the state, not as a result of pursuing self-interested goals by the professionals. Some sociologists even viewed altruistic service as an inherent personal quality of the members of the profession (Barber 1963). Later in the century, Ritzer stressed that trait and functionalist writers have often confused studies of profession as collectivities and individual professional workers (Ritzer 1973; Ritzer 1992).

Following the functionalists and trait writers, professionals were supposed to see their work as a kind of mission or calling. Unlike people whose work was considered to be an occupation, and who were taken to lack the feeling of 'commitment' to their work-activity, professionals were assumed to remain committed to an area of work during their life span. At the same time, the rewards to professionals were higher and the period of adult socialisation was prolonged. Members of the profession were less willing to leave an occupation, and were more likely to assert that they would choose the same work if they were to begin again.

The level of development of formal (written) and informal ethical codes for recruits to the profession were seen as an important indicator of professional altruism, and as one of the key concepts of whether an occupation could be called a profession (Hall 1975: 74). Ben-David (1960) argues in his trend report on professions in the class system that one of the most important distinguishing characteristics of the professional organisation and behaviour is the existence of a vocational subculture which comprises explicit or implicit codes of behaviour or generates an *esprit de corps* among members of the same profession. It also ensures them certain occupational advantages, such as an egalitarian rather than authoritarian type of supervision in bureaucratic structures and monopolistic privileges to perform certain types of work.

Millerson wrote that an ethical code could be both formally and informally enforced, through censure, removal from the professional association, or professional ostracism from interaction within the group (Millerson 1964). He undertook an examination of over one hundred and thirty British qualifying associations, and found that about a



quarter had formal written codes (Millerson 1964: 28-29). The reminder most probably included at one extreme organisations which had well developed but unwritten codes, and at the other organisations which had developed hardly any ethical norms, with the majority of organisations falling somewhere in between.

### **1.1.3. Professional autonomy**

It has been argued that professionals enjoy a high level of autonomy as a result of the self-regulation granted to them by the state. The trait and functionalist writers saw professional autonomy as a derivative characteristic, based on both the mastery of a knowledge field and commitment to the ideal of service. At a later date, social researchers stated that autonomy had to be justified through internal (peers and professional associations) and external regulation (Allsop 2002: 79). However, within the framework of the functionalist social paradigm, autonomy was mainly seen from the perspective of ‘immunity’ of the professionals from the lay public and the interference of the state. Autonomy revealed the scope of freedom of the professional group, to regulate their work activity and make decisions autonomously in the practice of their work (Freidson 1970)<sup>2</sup>. Professional autonomy was often understood as professional authority over the client: the professional can dictate what is good or bad for his client (Barber 1963; Hall 1983). As Goode postulates: ‘Professional autonomy – in a bureaucratic era, this means having one’s behaviour judged by colleague peers, not outsiders’ (Goode 1969: 291).

The existence of a professional community was conceived as an important criterion of the formation of a professional identity and professional autonomy. In the definition of a profession, functionalist and trait writers attributed ‘community’ characteristics to the profession and thought that the ‘kinship’ identity and similarity of destinies united the profession, just as much as a common professional culture, values and norms. Profession was seen as a collectivity with a sense of common identity, which can take control of its own members. As Pavalko argues their common norms usually relate to the behaviour of professionals at work, although they can be extended to the political views of the professionals, their leisure time activities and interpersonal attitudes (Pavalko 1972: 86). Goode argues that the professional association can be characterised

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<sup>2</sup> Freidson could not be seen as a functionalist and trait writer, even if some of his views overlapped with their views.

by the institutional manifestations of a community: (1) a common identity and common values; (2) their lifelong commitment to the profession; (3) role expectations imposed on the members of the profession are similar and egalitarian; (4) there is a specific language that is obscure for the uninitiated; (5) the professional community has power over its members (Goode 1957).

In summary, from the material presented above, three professional characteristics – professional expertise (knowledge-base), professional altruism (the ideal of service to the public) and professional autonomy – were seen as constituting the image of an ideal profession. Later this model was criticised. It was claimed that there was difference between the ‘essential’ and the ‘accidental’ attributes of a profession. However, in the ‘golden age of functionalism’, these characteristics were not seen as contentious. Their importance was explained by the general significance of the professions in the wider social context, although trait writers did not comment why particular attributes or their combination were significant in constituting a profession.

Functionalist researchers have seen the professions as centrally significant, very effective, and apolitical social institutions within society. This view was largely rooted in the classical works of Durkheim, who laid emphasis on the importance of professional ethics (Durkheim 1933). His view that the division of labour and occupational groups represented the moral basis for modern society led him to focus on the professions as entities which embodied all the social functions which he valued and which would act as intermediates between individuals and the state (Durkheim 1933). These Durkheim believed would save modern society from the breakdown in moral authority, which in his view threatened it. The development of this view was presented in the works of functionalist researchers in the twentieth century (Tawney 1921; Carr-Saunders and Wilson 1933; Parsons 1951; Ben-David 1964; Halmos 1970). Carr-Saunders and Wilson, for example, saw professionals as being one of the most stable elements in society, which inherit, preserve and pass on traditions: ‘the great professions, stand like rocks against which the waves raised by [crude forces which threaten steady and peaceful evolution] beat in vain’ (Carr-Saunders and Wilson 1933: 497).



This echoes with the article for the International Encyclopaedia of the Social Sciences written by Parsons (Parsons 1968: 545):

‘The professional complex, though obviously still incomplete in its development, has already become the most important single component in the structure of modern societies. It has displaced first the ‘state’ in the relatively early modern sense of the term, and, more recently, the ‘capitalistic’ organisation of the economy. The massive emergence of the professional complex, not the special status of capitalistic or socialistic modes of organisation, is the crucial structural development in twentieth-century society.’

Parsons showed that the individual collegial organisations of the professions and the hierarchical organisations of a monocratic bureaucracy rested their authority on the same principles: functional specificity, the restriction of their domain of power, and the application of impersonal standards on a universalistic basis, without regard to the personal characteristics or circumstances of their subjects (Parsons 1968: 570). At the same time, he viewed the profession as a preferable alternative to a bureaucratic organisation, by virtue of its collegial organisation and the common identity of its members, as opposed to a hierarchy and managerial control within a bureaucratic organisation. Thus, Parsons as other functionalist and trait writers, mainly viewed professionalisation as a ‘process with an end-state towards which certain occupations are moving and others have arrived’ (Johnson 1972: 22). However, even in the era of social functionalism, some sociologists pointed out that the significant question to ask about occupations was not whether or not they were professions but to what extent they exhibited characteristics of professionalisation (Vollmer and Mills 1966). These approaches are discussed further.

## **1.2. The trait and functionalist approach: defining ‘professionalisation’**

Trait and functionalist writers considered professionalisation to be a complex process in which various occupations came to exhibit a number of attributes that were ‘essentially’ professional or were said to be the core elements of professionalism (Carr-Saunders and Wilson 1933; Caplow 1964; Wilensky 1964; Hall 1968). Professionalisation was mainly understood as a process of the formation of a new profession out of a former occupation, by means of the deliberate copying of the characteristics of the conventional professions (mainly law and medicine). Vollmer and Mills (1966: 7-8) claimed that



‘The concept of ‘professionalisation’ [may] be used to refer to the dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of a profession... Professionalisation might be defined as a process by which an organised occupation, usually but not always by virtue of making a claim to special esoteric competence and to concern for the quality of its work and its benefits to society, obtains the exclusive right to perform a particular kind of work, control training for and access to it, and control the right of determining and evaluating the way the work is performed’.

Caplow argued that there was a ‘natural history of professionalisation’: a determinate historical sequence of events through which all professionalising occupations passed in identical series of stages (Caplow 1964: 139). According to him, all non-routine white-collar occupations were in the process of being professionalised to some extent. He stressed that the steps involved in professionalisation were definite and even the sequence was explicit and could be predicted; so that it might be illustrated with equal facility from the example of newspaper reporters (journalists), real state agents (realtors) or even undertakers (morticians) and junk dealers (salvage consultants). Caplow (1964: 139) argued that:

- The first step is the establishment of a professional association, with definite membership criteria designed to keep out the unqualified.
- The second step is the change of name, which serves the multiple function of reducing identification with the previous occupational status, asserting a technological monopoly, and providing a title which can be monopolised, the former one being usually in the public domain.
- The third step is the development and promulgation of a code of ethics which asserts the social utility of the occupation, sets up a public welfare rationale, and develops rules which serve as further criteria to eliminate the unqualified and unscrupulous.
- The fourth step is a prolonged political agitation, whose object it is to obtain the support of the public power for the maintenance of the new occupational barriers. Concurrently with the fourth stage, goes the development of training facilities directly or indirectly controlled by the professional society.

Wilensky in his famous ‘Professionalisation of Everyone?’ contested Caplow’s view that many occupations were in process of ‘professionalising’ (Wilensky 1964). He pointed out that very few occupations would achieve the authority of established



professions. Moreover, he elaborated his own model of professionalisation, which, he acknowledged, drew on Caplow's, but surpassed it as providing a more precise and well-grounded approach. Thus, he argued, the natural history of professionalism in the United States had consisted of five stages: (1) the emergence of a full-time occupation; (2) the establishment of a training school (or a university training); (3) the foundation of a national professional association; (4) political agitation in order to gain the protection of the association by law; (5) the adoption of a formal code (Wilensky 1964: 142-6).

The majority of the social scientists writing on the problem of professionalisation later in the century have used Wilensky's model as a starting point. Although critics pointed out a number of drawbacks, it stimulated much of the thinking in the field. Wilensky himself did not fail to notice some of the shortcomings of the model: one was that the succession of stages could in fact vary; although it remained unclear to what degree and for what reasons (Siegrist 1990: 181). Goode conveyed a similar idea that the stages depicted by Wilensky might go on simultaneously: 'So that it is difficult to state whether one actually began before another. For this reason, such a sequence is both time-bound and place-bound and thus accidental rather than theoretically compelling' (Goode 1969: 275). It was also argued that in spite of the fact that the model was deduced from the development of professions in the Anglo-American context during the nineteenth and twentieth centuries, still quite a few of the examples cited did not 'fit' (Hall 1968; Goode 1969; Johnson 1972; Collins 1990). Johnson, for instance, doubted the existence of a 'natural history of professionalisation' and argued that there was a clear-cut distinction between the formation of the professions in the United States, Britain and its colonies (Johnson 1972: 28).

These variations in sequence and timing have suggested that there is no uniform or 'one-way' evolutionary process of professionalisation, which is of universal applicability. Moreover, the trait and functionalist models of professionalisation did not include any systematic treatment of the general social conditions under which professionalisation took place. Variations in the role of governments and academic organisations were not analysed, whereas they have substantially affected the control and institutional forms of professional occupations. Collins suggested that the model of professionalisation coined by Wilensky stood 'at the watershed between the 'classic' and 'revisionist' theories. Although it looks backwards in laying out a sequence through



which all professions presumably pass, it looks forward in so far as it is a model of occupational closure based on power' (Collins 1990: 14).

## **2. Critiques of the trait and functionalist model of 'profession' and 'professionalisation'**

### **2.1. Early critiques of the trait and functionalist approach**

The early critiques of the trait and functionalist model threw into focus the issue whether all the listed attributes turn an occupation into a profession, or have some of those attributes, which have been derived from the model professions of law and medicine, happened by chance, and whether they could be changed or even disregarded without changing an occupation's claim to profession. Hall became the first social scientist, who has distinguished professional traits into essential ('structural') and accidental ('attitudinal') (Hall 1983). Although it is important to note that earlier in the century, Parsons stated that there were 'statuses', structural elements, certain positions within the stratification model that were not characteristic of the individual or of interaction, whereas behaviour was shaped by roles (Parsons 1951: 5-6). The social structure determined roles and shaped behaviour. The basic unit of the social system for Parsons was the status-role bundle or complex, however, he did not separate professional attributes into 'structural' statuses and 'attitudinal' roles.

Hall, in turn, clearly recognised an attitudinal or accidental dimension of the professional variables, that is, the social attitudes of the professionals or the social 'orientations of the persons involved' (Hall 1983: 75). By structural attributes he meant the 'factual' characteristics which become part of the social structure in the form of professional training schools, organisations, educational requirements. Whereas, according to him, the following attributes of the profession were attitudinal (Hall 1983: 75-76): (1) the use of the professional organisation as a major reference; (2) a belief in service to the public; (3) a sense of calling to the field; (4) autonomy, which involves the feeling that the practitioner is to be allowed to make decisions without external pressures from clients, from those who are not members of his/her profession.

Hall clearly recognised the fact that such characteristics as, for example, the belief in service to the public and autonomy were 'attitudinal'. It followed that these



characteristics could not be used as 'built-in' characteristics of the profession, as they were in no way 'social facts'. They could be present or absent. Moreover, Hall managed to show that the profession was not just an 'answer' to the needs of the society, fixed in a static social position within the societal hierarchy, but also a result of social activity of individuals oriented towards a certain goal, that was to encourage other members of society to see themselves in a certain way.

Becker and Hughes can also be seen as early critics of the 'ideal model' of the profession (Becker 1962a; 1962b; Hughes 1963). Their work was the outcome of an interactionist social tradition which took as its subject matter the social acts of individuals and groups, and how they constituted their social world as participants. The symbolic interactionist school of thought has emphasised 'action', with how things get done in society and a concern with the social construction of reality. Glaser and Strauss (1967) conveyed this idea by saying that this kind of sociologist wants answers to the question – what is going on here? While Hughes confessed that in his own studies he passed from the false question – is this occupation a profession? – to the more fundamental one – what are the circumstances in which people in an occupation attempt to turn it into a profession, and themselves into professional people? (Hughes 1963). By treating the concept of professionalism simply as a socially negotiated label, interactionist contributors were able to cast doubt on the 'built-in' characteristics of the profession accepted at the time – including the notion of professional altruism which was seen to be belied by the actions of unethical practitioners in the fold (Saks 1998: 15). Drawing largely on a micro-analysis of the world of professions, this sceptical approach paved the way for the macro-critiques that increasingly emerged in the late 1960s.

## **2.2. The Marxist and neo-Weberian approach: defining 'profession' and 'professionalisation'**

In the 1970s, views on the professions started to change. The general public was faced with examples of the inadequate levels of competence and professional corruption. The idea of altruistic professional service was called into question. At the same time, a major shift occurred in social science from the structural functionalist orthodoxy to a much more pluralistic scene, in which sociological conflict theory and an action-based conceptualisation began to play an important role (Collins 1990: 24). Neo-Weberians and Marxists came to the foreground of social research. The change was important for



the sociology of the professions, as up to that time, the professions had been considered ethically positive embodiments of the 'central values' of the society. Critics felt that this approach reflected too closely the ideological image which professionals tried to convey of their own work. The functionalist and trait writers started to be seen as 'victims' of an uncritical acceptance of the professional claims to such attributes as ethical behaviour, altruism and community service.

Thus, it has been claimed that the functionalist and trait writers confused 'descriptive' and 'normative' definitions of profession. A descriptive definition gave attributes that were essential for an occupation to be a profession and did not say anything about what professions ought to be like. Conversely, a normative definition gave the ideals that professionals ought to pursue and realise. But it was not always apparent whether a descriptive or normative type of definition was meant. As Grossman commented: 'When we are told that those in a profession pledge themselves to promoting the well being and interests of their clients, is this given in the sense that a pledge does exist or in the sense that professionals ought to have such a pledge?' (Grossman 2004: 2)

By the mid-1970s, two new models of the profession and professionalisation appeared: the neo-Weberian model of 'the profession as a monopoly' and the Marxist model based on the 'relations of production'. Despite all their differences, the followers of these approaches tended to focus on the analysis of professional power and managed to move away from a static functionalist definition of the profession as being apolitical and homogeneous communities of competent individuals.

### **2.2.1 The Marxist approach: defining 'profession' and 'professionalisation'**

Marxist social researchers argued that the changes in the relations of production have been the main forces shaping the historical development of health provision in Britain and the United States (Haug 1973; Navarro 1976; Esland and Salaman 1980a; McKinlay and Arches 1985; McKinlay and Stoekle 1988). The Marxist definition of the professions leaned towards the classification of professionals in a class schema. Some Marxists assumed that professional groups were a component part of the 'bourgeoisie' class contributing to capital accumulation by dealing with the disease and diswelfare associated with life under advanced capitalism (Picciotto 1979; Esland 1980a; Esland 1980b; Navarro 1986). Within this frame of reference, critiques were oriented toward



revealing that the claims of altruism of the professions were nothing more than a mask for professional self-interest and their control and surveillance functions for the benefit of the dominant bourgeois class. Saks commented that the critical thrust of Marxists was mirrored in the depiction of the oppressive role of professions in Western capitalist countries (Saks 1999a; 1999b). Picciotto, for example, believed lawyers sustained capitalist wage-labour relationships (Picciotto 1979). Esland saw welfare professionals like social workers, educational psychologists and counsellors as upholding the capitalist social order which prevented them from effectively ameliorating the difficult circumstances of their clients (Esland 1980a; 1980b). And Navarro viewed the medical profession as operating with delegated authority to run the house of medicine on behalf of the bourgeoisie (Navarro 1986).

Other Marxist writers were concerned with the issue whether professions were becoming 'proletarianised' or 'deprofessionalised' (Oppenheimer 1973; Braverman 1974; McKinlay and Arches 1985; Murphy 1990). McKinlay and Arches, for example, used the term 'proletarianisation' to 'denote the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism' (McKinley and Arches 1985: 161). McKinley and Arches have identified seven specific professional prerogatives as diminishing for physicians: control over (1) criteria for entrance, (2) control of training, (3) terms and content of work, (4) objects of labour (e.g. clients served), (5) tools of labour (equipment, drugs, etc.), (6) the means of labour (premises, etc.), (7) amount and rate of remuneration (McKinley and Arches 1985: 161-162). This idea resonates with the statements of Larson in her Marxist mould that physicians face increasing economic, organisational and technical alienation from their labour (Larson 1977: 67).

All social researchers working in the Marxist tradition have shared the view that in modern society there are certain processes at work, which are the consequence of the capitalist relations of production on which the society is based (Navarro 1986). And the professions in one way or another – as a part of the capitalist class or as a part of the proletariat – are bound up in the process of the state formation, the polarisation of social classes and the monopolisation or devastation of the means of production. Extensive criticisms of these arguments have been put forward by, amongst others, Freidson (1986), Rosenthal (1987) and Elston (1991). According to Elston, among the general



criticisms that can be made of the proletarianisation of medicine thesis are the following:

‘Its acceptance presupposes the validity of the general account of progressive proletarianisation of virtually the entire labour force in advanced capitalist societies and the identification of this process with Weber’s ideas about bureaucratisation... The evidence presented is generally weak or ambiguous, particularly concerning physicians behaviour in these bureaucratic organisations. The same observations sometimes appear as both cause and effect of the proletarianisation process’ (Elston 1991: 63).

Thus, there are grounds for accepting the argument of Freidson that ‘proletarianisation’ itself remains unarticulated as concept, making its applicability to the medical profession unclear. He states that it is perhaps more of ‘a slogan’ rather than an analytical concept (Freidson 1986: 15, 21). This parallels Saks’ arguments that most Marxist claims have been tautological, given that they are based on a structuralist view of the state that is seen as invariably serving the needs of capitalist production (Saks 2003a). Marxist approaches did not evaluate the extent to which the theory stood up empirically. Marxists, for example, did not specify the distinctive elements of the control and surveillance functions in which professions in general and the medical profession in particular were held to be engaged (Saks 2003a: 43-5, 54). Saks also claims that there are significant theoretical difficulties in including the medical profession into the ruling class, as its members are not necessarily owners of the means of production.

Some social researchers within the Marxist camp more fully recognise the intricacies of relationship between the state, the bourgeoisie and the professions. Wright, for example, in his model of an American working class pays tribute to the various cleavages and divisions among professionals who sell their labour power (Wright 1985). Some professional occupations he places in a distinct ‘semiautonomous class’ by virtue of their control over the work process, and some professional occupations, namely upper-level supervisors, he locates in a ‘managerial class’ by virtue of their authority over workers (Wright 1985). It should be noted that the dividing lines proposed in this model rest on concepts (e.g., autonomy, authority relations) that were once purely the province of Weberian or neo-Weberian sociology.



Johnson, in turn, saw professions as agents of capital in the labour process, not as members of the capitalist or the proletariat class. He claimed that the professional form of occupational control can emerge only: ‘...where core work activities fulfil the global functions of capital with respect to control and surveillance, including the specific function of the reproduction of labour power’ (Johnson 1972: 106). Thus, in the case of medicine, doctors monopolise official definitions of health and are able to define and legitimate the withdrawal of labour. However, as Saks argues, ‘interesting as this notion is...similar problems of operationalisation arise in health and other context in explaining the dynamics of professionalisation if the boundaries between the state and professions are obscured in this way’ (Saks 2003a: 45).

Thus, critics have suggested that a Marxist understanding of professions in capitalist society is a ‘too doctrinaire’ ideology (Berger 1982: 15). It draws on the fundamentalist Marxism, which is crudely deterministic, and also reductionist in its materialism, allowing little scope for human agency and subjectivity. And as it has been highlighted, Marxism is often seen as ‘grand theory’, eschewing empirical research. The following neo-Weberians have sought to avoid the pitfalls of Marxist interpretations. They, instead of seeing occupations as having fixed positions within a market, took them as the status groups in the realm of work, which instead of merely responding to market dynamics, as in the model of class stemming from Marx, attempt to control market conditions.

## **2.2.2. The neo-Weberian approach: defining ‘profession’ and ‘professionalisation’**

### **2.2.2.1. The neo-Weberian approach: defining ‘profession’**

This thesis follows a neo-Weberian theoretical approach to its subject matter. In this approach, the focus of the research is shifted towards the study of various professional strategies to monopolise a certain and privileged position in the labour market (Larson 1977; Parkin 1979; Collins 1990; Saks 2003a; 2003b). Similar to Marxists, neo-Weberians have no longer seen specialised knowledge or altruistic behaviour as essential characteristics of the profession (Waddington 1984). However, claims to such attributes were important, as Freidson affirmed, in so far as they constituted the rhetoric in terms of which occupational groups seek to obtain from the state special privileges of

a protected market situation through the system of licensing and self-governance (Freidson 1994; 2001).

Let us start from the search for definition of the profession within a neo-Weberian perspective. Macdonald argues that professions fit well into Weber's definition of 'status groups', striving both economically and socially to advance within the labour market (Macdonald 1995: 30). Following Weber, classes are categories of people who have similar economic interests and are in similar positions within economic markets and they can be transformed into status groups when they go beyond the cold material calculation of market interests (Weber 1968: 927-28). That is to say, they become 'status groups' when they become communities, sharing a felt identity, ideals and set standards for their conduct collectively. These communities can compete, coexist, or overlap with class-based groups. According to Weber, professions are interest groups engaged in competition with each other and with other groups in society up to, and including, the state (Weber 1968: 927-28). Such groups may pursue economic interests, but may well have other motives for their collective actions as well, for example, the pursuit of social status in a quite distinctive manner (Macdonald 1995: 31). In terms of Weber's model of stratification, a profession operates in both the economic sphere and the social sphere.

The strategies that professionals deployed over time to engender a high social position and to pursue their interests are connected with the distinct place of professionals in society, as their 'opportunity for income' derives from their knowledge and their qualifications, and, as Weber sees it, this gives them a significance on a par with those whose class position derives from either their capital or labour power (Weber 1947: 424-29). This class position is to some extent determined by the structural features of industrial society, but the actions of members of society, especially the collective action of groups, are always of significance and can usefully be conceptualised as a strategy of social closure (Weber 1968; Collins 1975; Parkin 1979; Macdonald 1985; Murphy 1988).

By social closure Weber was referring to the processes by which groups devise and enforce rules of membership; the purpose of such rules typically is to 'improve the position [of the group] by monopolistic tactics' (Weber 1968: 341-48). In other words, the process where collectively conscious groups (corporate groups) in the course of



furthering their interests attempt to exclude others from their group and to usurp the privileges of other groups (Parkin 1979: 49). Social closure lies at the heart of Collins' definition of professions which he considers to be 'a combination of market closure with high occupational status honour' (Collins 1990: 36). This definition resonates with the classical neo-Weberian definition of the profession coined by Larson. According to her, professional groups are those occupations which can translate one order of scarce resources – expertise created through standardised training and testing at the higher levels of the formal education system – into another – market opportunities, work privileges, social status or bureaucratic rank (Larson 1990: 30):

'Profession is thus a name we give to historically specific forms that establish structural links between relatively high levels of formal education and relatively desirable positions and/or rewards in the social division of labour.'

Within the neo-Weberian approach, the dimensions of market control and social prestige of the professions are closely connected, to such an extent that Larson describes them as 'two...distinct analytical constructs which can be 'read' out of the same empirical material' (Larson 1977: 66). Macdonald claims that the professional group tries to get into a benign spiral of interaction between these two aspects: if they seem respectable, they can attract business; if they are economically successful they can afford more outward signs of respectability (Macdonald 1995: 188). The collective pursuit of economic advantage is, in a sense, more important, but cannot in the nature of things be separated from the drive for respectability. Larson (1977: 66) argues:

'The success of the professional mobility project depended on the existence of a stable market; but also, in the process of securing a market, the professions variously incorporated ideological supports connected with the 'anti-market' structures of stratification. These pre-industrial structures provided both models of gentility toward which nineteenth-century professional men aspired and images which legitimised status inequality'.

Johnson in his initial work derived from a neo-Weberian frame of reference also stresses the importance of the dimensions of market and social prestige for the development of professions. He argues that professionalisation – based on the occupational authority of the producer over the consumer – came into being, where consumers formed a large, heterogeneous group (Johnson 1972: 22). He observes that this type of control emerged in medicine with the development of industrialisation and

urbanisation of the country, which provided an expanding market for medical services and broke the bonds of upper-class patronage (Saks 2003a: 46). Johnson also stresses that upper-class recruitment to medicine increased its standing and furthered the process of professionalisation.

To summarise, neo-Weberians have conceptualised professions as an institutionalised form of monopoly and/or power based on knowledge and skills maintained by particular relationships with the state and the market (Grossman 2004: 2). They viewed the rather high position of professions in the society as something that the professions had to work at, and once it was reached, wished to protect and enhance (Larson 1990: 30). The reinterpretation of the definition of 'profession' was accompanied by the change in the definition of the term 'professionalisation'. As the following analysis will show, professionalisation has been portrayed in different ways: from a process in which professions achieve relative autonomy from the market and the state, to a social mobility project in which occupations strive towards commercial and social advantage by being resistant to competition (social closure) and alternative forms of accountability (Grossman 2004: 1-3).

#### **2.2.2.2. The neo-Weberian approach: defining 'professionalisation'**

From the 1970s, the boundary between the 'professional' and 'non-professional' occupations started to be viewed as permeable. 'Professionalisation', within the frameworks of the neo-Weberian approach, started to be viewed as a strategy of monopolistic control over the market for particular services which brings about upward social mobility (Parry and Parry 1976; Larson 1977; Parkin 1979; Collins 1990). As it has been argued, neo-Weberians no longer viewed social mobility and market control as mere facts of social life; that is, they were not seen as direct reflection of expertise, skills or ethical standards of the professionals. Social mobility and market control were considered the outcome of the 'professionalisation' defined by Larson as an attempt to translate one order of scarce resources – special knowledge and skills – into another – social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, and monopoly of status in a system of stratification (Larson 1977: 66).



Larson (1977) in her earlier works suggested the term 'professional project' instead of 'professionalisation'. As Macdonald argues, the term 'professional project' may be seen as the cognate to the notion of 'career', which was first used in the works of symbolic interactionists and later on extended to professions in the work of Hughes, Freidson, and Larson (Macdonald 1995: 188). By the term 'professional project' these social researchers understood a professional group 'career' or, in other words, a professional group upward mobility. The preference given to the term 'professional project' may be primarily explained as an attempt to accentuate the social activity of the professions themselves and to refrain from the functionalist view of professionalisation as a result of the transformation of social structure. And it may be viewed as an endeavour to avoid the phenomenological background of the notion 'professionalisation', previously understood as a formation of an ideal type of the profession within the historical context of the United States of America and Great Britain.

However useful this concept may be, it has not received wide dissemination. The majority of social researchers of the sociology of professions still adhere to the term 'professionalisation', which in the course of time embodied the notion of action, conflict and competition, that Larson tries to convey by the term 'professional project'. It is also important to mention that 'professionalisation' cannot be substituted by the term 'social mobility'. As Ilyin argues the upward social mobility of professions, gender groups and ethnic minorities have had both common features and significant differences (Ilyin 2000: 112). And the process of 'professionalisation' had some characteristic features, historically expressed both in the European and Anglo-American contexts, for example, the foundation of formalised educational programmes and the creation of codes of ethics. Thus, in this thesis, the concept 'professionalisation' will be favoured over the concepts 'social mobility' and 'professional project'.

Drawing on the neo-Weberian and other action-based social literature, this author has singled out a few defining aspects of 'professionalisation' (Johnson 1972; Larson 1977; Parkin 1979; Murphy 1988; Collins 1990; Macdonald 1995; Freidson 2001; Saks 2003a). This attempt should not be confused with the endeavours of functionalist researchers to define exact stages of professionalisation, given that the author recognises that the stages may be present or absent. The following model is an operationalisation of the concept of 'professionalisation' defined from a neo-Weberian perspective as interest-based occupational strategies aimed at gaining control of the market through the



establishment of exclusionary closure in a pluralistically conceived social order (Saks 2003a: 46). The following stages of professionalisation, probably, tend to lead to the monopolisation of a higher social standing of professionals:

- the claim for professional expertise, for exclusive rights in the knowledge base;
- the claim for professional autonomy;
- the formation of professional ideology;
- the formation of professional organisations;
- the social closure of the professional group;
- the maintenance of position.

Let us further explore the ways in which Anglo-American neo-Weberian and other action-based social researchers conceive of the above-mentioned constituent elements of professionalisation. It should be noted that the following analysis does not claim that professions and professional associations do nothing else apart from reaching and protecting the market monopoly for their expertise. This author agrees with Evetts that professionals not always initiate professionalisation projects and influence governments, they as often are *responding* to external demands for change, which can be political, economic, cultural and social (Evetts 2003: 25). However, according to the main goals of this thesis, the initiatives of professionals are thrown into the focus of the analysis, whereas external demands for change in the profession on the part of the state, consumers and other social actors will be indirectly reviewed through the response and countervailing actions of professionals.

### **Claim for professional expertise, for exclusive rights in the knowledge base**

Expert knowledge still remains ‘a core generating trait’ of professionalism (Halliday 1987). As well as legitimating high status it actually provides the means to activate social closure strategies (Larson 1990; Freidson 1994). As Cant and Sharma argue, if knowledge is deemed to be expert, only a small number of people with the appropriate qualifications and abilities will be in a position to mediate that knowledge (Cant and Sharma 1996a: 6). Collins, in turn, claims that knowledge constitutes the central resource of the conventional professions, as they tend to stake their claim for privileges on their educational qualifications and ‘would-be professions’ follow the similar route (Collins 1990: 37). Most social scientists still conceive of the nature of professional knowledge as central: as systematic, codified, generalised, abstract (Abbott 1988: 30),



as a ‘means of control of nature and humans’ (Murphy 1988: 246-7), as ‘applicable to any problem or aspect of the world’ (Macdonald 1995: 161), and as ‘value-laden’ (Halliday 1987: 37). The characteristic of knowledge as value-laden deserves further comment. Halliday argues that the differential success of various occupations largely depends on the fact of ‘whether the cognitive base is primarily of the descriptive or the prescriptive’ (Halliday 1987: 37). He believes that the normative professions – those which call on the authority of science and prescribe norms or standards – acquire the greatest share of public influence.

To date, scientific and biomedical knowledge is no longer declared to be beyond the scope of social, political, cultural and economic analyses (Giddens 1991; Beck 1992). The work of Kuhn established that scientists are not totally opened-minded investigators, but approach the exploration of the world from vested theoretical positions. They operate within a paradigm, a whole way of thinking and working which filters what they are likely to find acceptable or unacceptable in new work or in other traditions, ‘the proponents of different paradigms practise their trade in different worlds’ (Kuhn 1962: 149). Kuhn claims that science is characterised by phases of very conservative practice followed by periods of revolutionary upheaval, and it follows that there is no one science, and no one professional expertise (Cant and Sharma 1996a: 6). It has been argued, however, that expert knowledge still plays the role of power and control. For example, Foucault in his *Birth of the Clinic* describes how, in the eighteenth century, the practice of medicine more and more involved the objectification of the patient, the by-passing of the patients’ reported experience of his or her symptoms, in favour of the subjection of the body to the penetrating ‘gaze’ of increasing scientific medical enquiry – which in this century quite literally penetrates the body with scanning devices (Foucault 1975). The rise of a medical practice based on this objectifying ‘gaze’ is related to the requirement for more precise modes of surveillance and control of populations (Foucault 1975).

In respect of professions as systems, Foucault argues, following Weber, that the development of particular forms of expertise was a crucial element of the formation of governmentality understood as intimately interlinked professional dominance and state development in varying stages of their interactive history (Larkin 2002: 121). Through these stages, and in response to them, the character and purposes of the governance of professions has changed, and these changes have underpinned and conditioned new



types of statutory regulation. As Larkin argues, the nature of this relationship through evolution on both sides passed from a period of professional domination with the minimal state, to the rise of medico-bureaucratic alliance (Larkin 2002: 122). Claim for professional autonomy, self-regulation with statutory authority, however, remains to be the cornerstone of professional identity.

### **Claim for professional autonomy**

Johnson points out that there are other actors in the field where the group pursues its professional project. He distinguishes (1) the state; (2) academic institutions, and (3) 'existing and potential clientele' (Johnson 1972). Abbott (1988) suggests that there is one more actor – namely, other professions. All above-listed actors have various effects on the professionalisation process, as they may all impose their own definitions on the organisation of the occupation and the content of practice. Relations with the above-mentioned social actors may have both market and status consequences and none is more fateful than those with the state (Portwood and Fielding 1981; Macdonald 1995; Moran 1999). Practising professionals themselves have not always been the key actors in their development. There has been a variety of ways in which the state has acted and reacted toward the professions at different periods of time. In some European countries the state has served to enhance the status of intellectual workers by increasing autonomy and decision making powers – representing 'professionalisation from above' (Burrage 1990; Macdonald 1995). While in the United States and Great Britain, the state has changed from being rather non-interventionist to being proactive (Moran 1999).

Various classifications have been put forward of the different aspects of professional autonomy which might be exercised in relation to the state and over work activity (Ovretreit 1985; Shulz and Harrison 1986; Harrison and Shulz 1989; Freidson 2001). Three main categories recur: (1) economic autonomy, the right of doctors to determine their remuneration; (2) political autonomy, the right of doctors to make policy decisions as the legitimate experts on health matters; and (3) clinical or technical autonomy, the right of the profession to set its own standards and control clinical performance, exercised, for example, through clinical freedom at the bedside, professional control over recruitment and training or collegial control over discipline and malpractice (Elston 1991: 62). Freidson saw professionalisation as appealing to occupational groups as they could claim autonomy in decision-making and discretion in work practises; in



decision making in the clients or more generally the public interest and in some cases (e.g. the medical profession historically) even self-regulation or occupational control of the work (Freidson 1994).

In discussions of medical power, the concepts of autonomy and dominance have often been used interchangeably. They are closely related but an analytic distinction can be made between them. As Elston argues, 'medical dominance' should be taken to refer to the authority of medically qualified health workers over others (Elston 1991: 61). This authority can, following Starr be subdivided into social authority, i.e. medicine's control over the actions of others through the giving of commands, and cultural authority, i.e. the probability that medical definitions of reality and medical judgements will be accepted as valid and true (Starr 1982: 12-13). It follows that professional autonomy refers to the legitimated control that an occupation exercises over the organisation and terms of work (Freidson 2001), whereas social and cultural authority have to do with the control over the actions of lay public and occupations subordinated to medicine (Starr 1982). Professional authority can be largely explained by the deployment of a professional ideology.

### **Formation of professional ideology**

Within the framework of the action-based approach, social scientists have emphasised that professional occupations surround their work with an ideological covering (Porter 1995), whereas in the trait and functionalist works, the professions were viewed as a 'calling', not merely a job. The activity carried out from 'high motives of altruism, of glory, or of moral, spiritual or aesthetic commitment rather than for mundane gain' (Collins 1990: 35). Revisionists of the functionalist approach stress the fact that the high-status professions are occupations with high pay and power, which suggests that the idealisation of work is something additional to other rewards, and not a substitute or compensation for them (Freidson 1994). The point that the professions appeal to the moral status of their work in order to demand a 'status appropriate wage' and a justification for their high social position is well argued in the paper by Duman on the creation of professional ideology in the nineteenth century (Duman 1979: 38):

'Central to this process was the formulation and diffusion of a unique ideology based on the concept of service as a moral imperative. This provided doctors, lawyers, clergymen and the members of an evergrowing number of other

occupations with an article of faith with which to justify their claim to superior status and special privileges, such as self-discipline’.

Freidson (1994) has also examined the potential for producing an ideology possessed by a successful profession. He comes to the conclusion that the successful deployment of the professionals’ cognitive and normative aspects not only allows some occupations to establish their social status, it also provides the potential for defining social reality in the area in which members of the profession function. That is, the ideology gives the professions the opportunity to use their technical expertise as the basis for a claim to a universal validity for their public pronouncements. While they can in some circumstances extend this well beyond their particular domain, they typically use it to define the standards by which their competence will be judged and the extent to which the laity can enter their domain.

The understanding of Freidson of the professional ideology somewhat corresponds to the interpretation of the term ‘ideology’ by social constructionists, who interpret ideology as ‘knowledge deployed in the service of power’ (Burr 1995: 82). Burr claims that a version of events, or a way of representing a state of affairs, may be true or false. But it is ideological to the extent that it is used by relatively powerful groups in society to sustain their position (Burr 1995). Thus, ideas in themselves cannot be said to be ideological, only the uses to which they are put. The study of professional ideology is therefore the study of the ways in which meaning is mobilised in the social world in the interests of professional groups.

Moreover, the creation of professional ideology of the occupations striving for professionalisation is often oriented towards acquiring status honour expressed in ‘outward signs of respectability’ in their life-style. As Macdonald (1995: 189) argues there are status activities, which may be undertaken in ways that will be of significance for the evaluation of the occupation by others, or for the moral and self-image of the members, for example, such as the location of offices, the eating of lavish dinners or the granting of a coat of arms. Collins also stated that a professional ideology that produces an honorific status is largely based on the outward signs of respectability, and is generated by professionals who are ‘specialists in ritual’ (Collins 1990: 37).



However, professionals cannot keep afloat only on pursuing interest-based occupational strategies aimed at gaining control of the market through the establishment of exclusionary closure (Macdonald 1995; Saks 2003a). As Macdonald argues, while there is no need to revert to the functionalist view, which takes professionals entirely at their own evaluation, professionals are providing the services that they claim to provide in relation to the life, health, property and other matters of crucial importance to their clients (Macdonald 1995: 101). Some of their actions may be concerned with self-enhancement, but the reverse side of the coin is that what they provide is still a service for their patients or clients. This approach echoes with Saks' understanding of the dual nature of the professional behaviour, which, in his view, is akin to the mythical Minotaur – part human, part beast. The analogy drawn suggests that the 'precise balance of the positive and negative features of the professions is not yet known and the nature of the contours of the profile need to be firmed up' (Saks 1999b: 21). Saks argues that there is a need to develop an analytical framework for assessing the altruistic ideologies of professions.

This thesis does not aim to assess the balance that is struck between self-interests and the public interest of physicians. However, here this author tries to adhere to a more stable interpretation, which acknowledges the dual aspect of professions which both attempt to protect their market position and promote public service. Often both these goals have been reached by Anglo-American professions through the formation of professional associations and collective activity.

### **Formation of professional organisations**

Organisations of professions and professionalising occupations have attracted special attention from neo-Weberian authors as the primary means both of exercising control over and access to basic occupational resources. Following Collins, honorific status makes professions different from occupations, as the latter relate to trade unions, which are mostly concerned with the rise in wages and the improvement of working conditions (Collins 1990: 41). The professions implement professional organisations and try to ensure that they control their own members through maintaining and regularly updating the ethical codes relating to professional practice (Allsop 2002). As far as it is

practically possible, they take steps to ensure that these are adhered to in day-to-day practice.

Burrage and colleagues stress the variety of forms of the professional organisations and distinguish four major, 'ideal types' of organisation (Burrage *et al.* 1990: 208). First, they suggest that there are 'learned societies': organisations that give prime emphasis to the knowledge-base of the profession, the discussion circle, scientific society or academy. Second, there are 'representative associations' which primarily seek to lobby on behalf of the profession and to obtain some legislative relief or support. Third, there are 'trade-union types of organisations' those that negotiate on behalf of their members and are often therefore barely distinguishable from trade unions. Finally, there are 'regulatory associations' that seek to regulate the members of the profession, the examining, certifying or as Millerson called them, 'the qualifying associations'. In reality, the authors think, these types of organisations may be combined in a variety of ways, and the goals of associations may shift from one priority to another (Burrage *et al.* 1999: 208).

Larson (1977:6) argues that the actions of the professionals are rather coherent and consistent, even though 'the goals and strategies pursued by a given group are not entirely clear or deliberate for all the members'. Quite often, the elite of the group formulates goals, motivates rank-and-file practitioners for their achievement, whereas individual members of the group can pursue their own ends and, at times, are unaware of the broader collective aims of the group. Moreover, following Burrage and colleagues, the goals and forms of professional organisations are not, however, solely a matter of the volition of practitioners, since they seem to be determined to some degree by the demands and pressures of the other social actors (Burrage *et al.* 1990: 208-11). 'The learned society', for instance, gives primacy to developing the knowledge base of the profession and hence shares the same goal as the university. 'The representative association' is primarily oriented towards influencing and shaping relations with the state. The trade-union type of organisation is primarily concerned to protect members having to deal with organised users of professional services, whether public or private. 'The regulatory association' is concerned with practitioners themselves. This correspondence supports the suggestion that the dominant form of professional association is the product of historically specific constraints and opportunities presented to practitioners.



In Western countries, professional associations, typically licensed by the state, have determined who is admitted into the group and who is not. Once established, strong professional associations have charters that regulate training and have rules that govern inclusion and exclusion and exercise a monopoly over certification, the creation and dissemination of expert knowledge and standards of practice (Allsop *et al.* 2004). Traditionally, professional groups determine the content of examinations; the terms, conditions and goals of education and training; and the numbers of 'recruits'. However, in practice in state-funded health and education systems, control over these areas tends to be shared between the profession and the state (Allsop *et al.* 2004). Typically, licensing boards are staffed with members of the profession or with people approved by the profession so that it is said to be 'self-regulated'. Professional associations establish both formal and informal types of quality control. This enables them to fulfil their obligation to protect the public – the condition for state licensed self-regulation (Allsop 2002: 83-84). They are obliged to identify poorly performing doctors and, if necessary, to exclude them from practice (see, for instance, Stacey 1992).

### **Social closure of the professional group**

As has been highlighted, most neo-Weberians employed Weber's concept of social closure, the idea that collectively conscious groups, corporate groups, in the course of furthering their interests attempt to exclude others from their group and to usurp the privileges of other groups (Parkin 1979). The outcome of successful professionalisation was often understood as a 'monopoly of competence legitimised by officially sanctioned 'expertise', and a monopoly of credibility with the public' (Larson 1977: 38). However, Larson's interpretation has not gone unchallenged (Evetts 2003: 24). Freidson, for example, preferred market 'shelters' to complete monopolies in professional service provision, which indicated the incomplete nature of most market closure projects (Freidson 1983). This position seems to be well-grounded in relation to state centralist societies like France and the former Soviet countries, for which social closure may be interpreted as a strategy which *may* bring legally underwritten professional monopoly. Moreover, the nature of professional closure in specific occupational fields can change over time (Collins 1990). This is similar to Saks' claims that opportunities for professional monopoly can be viewed as lying on a continuum, which may change over time (Saks 2003a: 1).



Social closure has always been the means by which dominant groups have achieved and maintained their position (Parkin 1979; Murphy 1988; Macdonald 1985; Collins 1990). Exclusive access to certain social rewards for eligibles might be based on controlling resources – physical property as well as on credentials. Parkin argues that social closure based on the monopolisation of qualifications and expertise has gained in importance. He chose as the subject matter of his research the social closure of the professions which controlled access to key positions in the system of the division of labour, using educational licensing (Parkin 1979: 16, 49). He claims that the increasing demands for new recruits into the profession, and constantly expanding complexity of the educational programmes are not always required in terms of the work done. Since the 1970s, most social researchers concerned with problems of education have seen it as primarily producing the closure of professionalising occupations (Bourdieu and Passeron 1977). However, a legally sanctioned monopolised position in the market cannot be acquired once and forever and professional groups get involved into the process of having to constantly maintain their monopolistic position.

### **Maintenance of position**

Burrage and colleagues argue that ‘organisation’ and ‘ideology’ are resources that professions share with many other kinds of interest and pressure group, but professions have another resource which distinguishes them from every other organised group (Burrage *et al.* 1990). They have tried to capture this by the term ‘persistence’. By ‘persistence’, they refer to ‘the remarkable uniformity and consistency in the goals of professions’ (Burrage *et al.* 1990: 209). The authors point out that whereas state institutions and state policies have changed greatly, the goals of the professions have remained virtually constant, even though the strategies for reaching them may have changed.

As has been highlighted, sociologists working within the framework of the action-based approach, do not conceive of social stratification as something that is a natural by-product of the economic structure or ‘the relations of production’. While these provide the basis of economic rewards and are therefore of great significance, position in society is also the outcome of interpersonal relations and thus something that individuals and groups have to work at. Macdonald emphasises that no group puts more into such



efforts than a professional body, even if, as in statist societies, their achievements are relatively modest (Macdonald 1995: 99). Thus, the professional body and its members must work constantly to promote their position, like Alice in *Through the Looking Glass*, 'It takes all the running *you* can do to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that' (quoted in McDonald 1995: 101).

To summarise, the constituent elements of the Anglo-American neo-Weberian model of professionalisation were considered. They imply: (1) the claim for professional expertise, (2) the claim for professional autonomy; (3) the formation of professional ideology; (4) the formation of professional organisations; (5) the social closure of the professional group; and (6) the maintenance of position. In this thesis, this theoretical model will be applied to the empirical study of the professionalisation process of orthodox and non-orthodox doctors in Russia in the following chapters.

However, it should be noted that neither this nor other neo-Weberian approach are flawless. One of the main critiques of neo-Weberians is their underestimation of the role of the state. As Le Bianic argues, neo-Weberians often hold in common their definition of the state as a 'legitimizing instance'. The state has not been seen as an 'actor' in the professionalisation process, its role is confined to the provision of a certain type of political and institutional environment which favours professionalism in liberal states and hampers in highly centralised (Le Bianic 2003: 6). This resonates with Evetts' ideas that the relations between the state and professions have been analysed one-sidedly within the neo-Weberian perspective and understood as a demand from professional groups to enhance its position, whereas they should be complemented by an understanding of the supply side. Thus, she claims that instead of the question – how do professions capture states? – the central question should be – why do states create professions, or at least permit professions to flourish? (Evetts 2003: 25). However, there is evidence that a renewed interest in the historical evidence about the parallel processes of the creation of modern nation states and of modern professions has already been fermented from a neo-Weberian perspective (see, amongst others, Larkin 2002; Saks 2003a; 2003b).

Other critiques deal with the fact that some key authors working within the neo-Weberian tradition, like Larson and Freidson, for example, provided too little empirical

detail for the claims presented (Collins 1990). However, this weakness applies to all of the current mainstream schools of thought considered (Allsop and Saks 2000: 3). Further analysis below aims at answering the question whether the Anglo-American model, particularly the neo-Weberian model of 'profession' and 'professionalisation', can be used to highlight the peculiarities of the development of continental European professions.

### **3. The applicability of the Anglo-American definitions of 'profession' and 'professionalisation' in Europe**

The sociology of professions has exceeded the limits of the Anglo-American context and started spreading over Europe since the 1970s and 1980s. Until then, 'continental' scholars had not found the professions to be worthy subjects of investigation, as they could hardly understand or translate the concept. Burrage postulates that American historians became the first social researchers on the European professions (Burrage 1990). They discovered and investigated the professions of continental Europe independently and in collaboration with continental historians and sociologists. As a result, more and more evidence was collected about continental professions and one could at last say that some similarities of the Anglo-American professions did exist on the continent and one could begin to explain why they had been neglected for so long.

The first critical question that was raised was whether it was correct that the 'attributes' of professionals were decided on the basis how the concept has been used in the English language. The French *professions liberales* (and still more *cadres*) were something different, and so were the *Akademiker* in Germany and Sweden (Torstendal 1990: 52). This is to say nothing about Eastern European and Russian *intelligentsia* (Mansurov *et al.* 2004). Thus, social scientists asked the question whether it was reasonable to take linguistic usages as the starting-point for social theory. Torstendal (1990: 47) argues that:

'A sound (irrefutable but also unavoidable) question is why we know that an analysis of professionalism should start out from the social relations of lawyers and doctors [in English speaking countries]... Most intriguing [will be] to imagine another linguistic world where engineers and primary school teachers were called 'infessional', and a theory of 'infessionalism' was formed from an



essentialistic analysis of the things engineers and primary school teachers have in common’.

The search for the definition of the ‘profession’ which could be appropriate for cross-cultural research led to the gradual rupture of the research on the professions with the ontological study of Anglo-American professions (Siegrist 1990). As it has been discussed, the early continental research was centred on the definition of the profession based on the three Anglo-American theoretical foundations, that is – ‘professional expertise’, ‘professional altruism’, and ‘professional autonomy’. Later, European social scientists came to a conclusion that the usage of the concept of ‘professional autonomy’ was not wholly defensible in the European context. As Collins (1990: 15) argues:

‘a reasonable strategy which emerges from current research would be to suggest there are two principal models of this wondrous occupation we are tracking down: (1) the Anglo-American, which stresses the freedom of self-employed practitioners to control working conditions; and (2) the Continental, which stresses elite administrators possessing their offices by virtue of academic credentials’.

According to Collins, the ways in which these professional occupations acquire this kind of social organisation and prestige differ greatly. Thus, a typical continental route was via the transformation of employment in a bureaucratic hierarchy, under the impetus of academic credentials. The driving force for the development of continental professions was primarily the growth of the state. Collins argues that ‘bureaucracy, academic credentialling, and a quasi-aristocratic life-style became fused to a degree which characterises the continental much more than the Anglo image of a profession’ (Collins 1990: 17). By contrast, a typical Anglo route, he claims, was the formation of a monopolistic practitioner group operating in a market for services. An occupation became a high-status profession by being granted self-regulation by the state.

Following Anglo-American critics of professions in relation to the altruism/service ideal, European sociologists have thrown into focus the instability and fluctuation of the normative characteristics of the profession and the fact that professional claims are often directed towards marking their sphere of particular influence (Torstendal 1990: 59). Altruism no longer was accepted as a constituting characteristic of the profession, especially in the health field (Le Bianic 2003: 6). Comparative analysis as well as



consideration of professional occupations in Europe showed that the only built-in ‘essentialist’ characteristic of the profession, probably, was cognitive specificity – the abstract, theoretical knowledge-base of the profession (Abbott 1988; Torstendal 1990; Collins 1990; Larson 1990; Macdonald 1995).

Abbott, for example, views a profession as an occupational group which has established jurisdictional control over a body of knowledge and its application. Abbott argues that professionals are engaged in a constant process of adjustment to social change and must actively protect their knowledge claims (Abbott 1988). This approach parallels to a degree the approach to professional work developed by Larson (1990: 30), which coined the definition of the profession suitable for comparative cross-cultural analysis:

‘The meaning of ‘profession’ – whether it emerges from the Anglo-American experience of the French-European – must perforce include the central function that professions (or their counterparts) have in the social practice of most advanced societies: that of *organising the acquisition and certification of expertise in broad functional areas, on the basis of formal educational credentials held by individuals*. If this can be accepted, then I think that a general structure of profession can be identified beyond the contingencies of politics, social status or nominal labels’ (emphasis in the original).

Thus, the social scientific researchers argue that expert knowledge-based groups or, in other words, professional groups that have a jurisdictional control over a body of knowledge and its application, irrespective of whether these groups are called professions or not in Britain or the United States, can be recognised as the basis around which a cross-cultural comparative research on the professions and professionalisation may be formed. Moreover, apart from an abstract theoretical knowledge-base, an important characteristic of the professions is their historically established opportunity to translate one order of scarce resources – special knowledge and skills – into another – social and economic rewards (Larson 1977: 66). As Collins affirms the broad outlines of the territory of the sociology of professions comprise different socially idealised occupations that have a rather high status in the advanced industrial societies (Collins 1990: 17) He suggests that analytically there is some unity behind all the occupational variants that are called ‘professions’ of one kind or another in different industrialised countries. All of them – ‘bureaucratic office-holders’, ‘licensed market-monopolisers’



and 'esoteric knowledge-holders' – to a certain degree, can translate their scarce cognitive resources into high social standing, status, self-governing powers and community organisation.

However, as has been highlighted, strategies deployed to engender a high social standing have been different in the Anglo-American context and in other European countries starting from 'social closure' to 'state support' (Larson 1977; Collins 1990; Johnson *et al.* 1995). As has been said, Collins claims that the difference in types of professionalisation of the Anglo-American and other European professions had to do with the fact that the former focuses on 'private government' within an occupation and the latter on the political struggle for control within an elite bureaucratic hierarchy (Collins 1990: 17). McClelland, in turn, distinguishes between 'professionalisation from within', namely successful manipulation of the market and the state by the professional group, and 'professionalisation from above', namely domination of forces external to the group (McClelland 1990; 1991).

The categorisation of McClelland was modified by Evetts who saw some problems with it (Evetts 2003: 30). Following her, McClelland tends to overemphasise the power of some Anglo-American professional groups to demand regulatory responsibilities from state, whereas she reconceptualised his ideas of 'professionalisation from within' and 'professionalisation from above' as a way of indicating different occupational constructions of, as well as benefits from, the use of the ideology of professionalism as an ideology of social control and occupational change. She claims that where the appeal to professionalism is made and used by the occupational group 'from within' the returns to the group can be substantial. In these cases, historically the group might have been able to use the ideology of professionalism in constructing its occupational identity, promoting its image with clients and customers, and in bargaining with states to secure and maintain its (sometimes self) regulatory responsibilities (Evetts 2003: 30-31). She goes on to argue that the realities of 'professionalisation from above' are very different. The effects are less the occupational control of the work by the workers and more by the organisational managers and supervisors. Organisational objectives which can also be political define practitioner/client relations and set achievement targets (Evetts 2003: 30-31).

To summarise, the Anglo-American definitions of the ‘profession’ and ‘professionalisation’ are applicable to the European continental professionals, if professions are seen as knowledge-based groups that have a jurisdictional control over a body of knowledge and its application, groups that may translate these rare cognitive resources into economic and social rewards. However, there have been important historical differences in the development of professional groups and the ways of escalation of their social standing in the Anglo-American and continental European contexts. There have been differences in rewards as well, as Anglo-American medical professionals have had a rather consistent social standing (relative independence from the state, cultural authority), whereas continental professionals have had an inconsistent social standing (high position in terms of cultural resources and lower position in the autonomy hierarchy).

## **Conclusion**

This chapter has outlined main Anglo-American theoretical perspectives concerned with studies of the professions and professionalisation. As the critical analysis of the most widely used definitions of the terms ‘profession’ and ‘professionalisation’ showed, to date the neo-Weberian perspective is more robust than the perspectives of the trait and functionalist researchers and of the Marxists. In the thesis, the author relies on the neo-Weberian definition of the profession and on the synthetic theoretical model of the professionalisation that broadly follows a neo-Weberian approach. Within the context of Russia, professionalisation is understood as the corporate actions of professionals to redefine the social characteristics of the profession within Weber’s dimensions of power, culture and wealth. Thus, the Anglo-American neo-Weberian concept of professionalisation as ‘an occupation developing into a monopoly’ is modified in this thesis into the concept of professionalisation understood as a low status profession’s striving to acquire a higher social standing and to secure a monopoly in the state sector or in the market. In the following chapters, relevant theories will be used to discuss the difference between the social standing of orthodox and alternative medical practitioners in Russia and present a historical analysis of their striving for professionalisation.



## II. ORTHODOX AND ALTERNATIVE MEDICINE: THE ISSUE OF TERMINOLOGY AND THE CHARACTERISTICS OF THE MAIN ALTERNATIVE THERAPIES

In the previous chapter, the scene for the thesis was set by outlining the mainstream concepts of the classic theories of professions and professionalisation with the aim of adapting Anglo-American theoretical models to the practice of medicine in Russia. It has been shown that most social researchers chose as an object of their research medicine as an occupation that traditionally enjoyed the prestigious title of the 'profession' (Freidson 1994). Professions were defined as knowledge-based occupations requiring higher specialised education having a jurisdictional control over a body of knowledge and its application, groups that may translate their scarce cognitive resources into economic and social rewards, and secure a monopoly in the market (Parkin 1979; Abbott 1988; Larson 1990; Torstendal 1990). It has been highlighted that the term 'profession' has referred to orthodox medical practitioners, while unorthodox practitioners have been deprived of the professional title, the desirability of which has grown for them in recent years (Saks 2003a: 148).

This chapter will explore the definitions of orthodox and unorthodox medicine in order to shed light on their differences in terms of approaches to treatment and in terms of their position in the wider social context. Emphasis will be placed on unorthodox medicine, as orthodox medicine was the focus of attention in the previous chapter. In Russia, orthodox medicine in relation to diagnostics and treatment is broadly similar to orthodox medicine of other industrialised societies (Davis 1989: 287), whereas unorthodox medicine has many distinctive features, which need to be specified in order to make cross-cultural comparisons possible (Karpeev and Kiseleva 2002). So, the main aim of this chapter is to analyse the existing definitions of orthodox and unorthodox medicine in Western countries and in Russia in order to elaborate the definitions of orthodox and unorthodox medicine, which will be used in the thesis. The first part of the chapter provides a frame of reference of what definitions of orthodox and unorthodox medicine have been accepted within the sociological tradition. The second part of the chapter is devoted to the current controversy over definitions in the sphere of Russian unorthodox medicine and the political discussions over 'the right' and 'the wrong' terms from the point of view of state medical officials and unorthodox medical



practitioners. It draws on selective findings of the independent interviews of alternative practitioners undertaken by the author in Moscow in 2003. The third part provides a glossary and short history of the main unorthodox therapies currently used in Russia. It gives an overview of all therapies that are officially allowed for practice in the country.

The phenomenon of unorthodox medicine has not yet received the proper attention of Russian social scientists. The author has reviewed major Russian sociological journals, including *Sociological Research (SOTSIS)*; *Sociological Journal* and *the Journal of Sociology and Social Anthropology* for the last ten years<sup>3</sup> and this showed that there have been no articles published on the subject. A new journal *Sociology of Medicine*, whose first issue was published in 2002, has not yet paid attention to unorthodox medicine. Nor have any monographs been undertaken. Fulder (1996: 2), a prominent British social scientist involved in unorthodox medicine research, argues that while the modern world is moving towards pluralistic medicine at a pace that has taken everyone by surprise, there is still ‘...very little in the way of comprehensive texts for professionals and for the interested public on what exactly alternative medicine is, what its practitioners do, how it arrived, what is its status and what is its future. This is the case as much today as ten years ago’.

The scope of literature on unorthodox medicine in the United Kingdom and the United States, however, is incomparably bigger than in Russia. There are excellent books which provide accounts of the history and basic principles of the unorthodox therapies and their characteristic techniques (Inglis and West 1983; Stanway 1986; Collinge 1996; Fulder 1996). There are also books that consider the social aspects of the development of unorthodox medicine (Sharma 1995; Cant and Sharma 1996a; Porter 1997; Vincent and Furnham 1998; Kelner *et al.* 2000; Saks 2003a). The definitions suggested by the key authors writing on the subject of orthodox and unorthodox medicine will be analysed in the chapter.

This chapter also draws on some Russian primary sources of information, such as Russian legislation documents, official papers of the Ministry of Health, and statistics. Some useful information was taken out of books written by prominent Russian unorthodox practitioners concerned with the issues of definition of unorthodox

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<sup>3</sup> *The Journal of Sociology and Social Anthropology* was reviewed since 1998, since it was first published.



medicine and its future (Anohin 1998; Neumivakin and Neumivakina 2001; Karpeev and Kiseleva 2002). As was mentioned, the chapter also incorporates some results of the independent interviews undertaken by the author in January-March 2003 in Moscow. They involved the interrogation of nineteen experts, who were well-known unorthodox practitioners, mostly heads of unorthodox professional associations (for details of the research see Chapter IV). This research among other things was aimed at understanding what definition of unorthodox therapies the participants of the research preferred and why this was so.

## **1. Frame of reference and definition of terms**

Social scientific researchers have suggested various definitions of orthodox and unorthodox medicine which can be subdivided into ‘essentialist’ definitions that try to define the field in its substantive characteristics and ‘politicised’ definitions that refer to the social standing of orthodox and unorthodox medicine in the society. The latter definitions make the issues ‘political’, in the sense that they are more aware of ‘political matters’ of the differential social support given to different types of medicine by the state, by other significant actors, and by consumers. Only consideration of both types of definitions will give full credit to the phenomena being analysed.

### **1.1. Politicised definition of orthodox and unorthodox medicine**

In Western countries, the official health system is referred to by a range of terms, such as ‘biomedicine’, ‘orthodox medicine’, ‘conventional medicine’, ‘scientific medicine’, or simply ‘modern medicine’. Among these terms biomedicine and orthodox medicine seem to be used more often than the others. Saks defines ‘orthodox medicine’ as including all forms of health care that are significantly supported by the state (Saks 2003a: 2). Medical orthodoxy in industrialised societies is based on biomedicine and is largely centred on physical medicine, the use of drugs and surgery (Davis 1989; McKee 2001). Saks, however, claims that there is not an inextricable link between biomedicine and medical orthodoxy (Saks 2003a: 2). Even though they have been synonyms for the past centuries or more in Britain and the United States, such associations can change as time progresses. As regards other terms used to refer to the official health care system, there has been a gradual shift away from the use of terms scientific and modern

medicine. Scientific medicine, as Vincent and Furnham argue, is an ideologically loaded term as it seems both to overstate the dominance of science in medicine and also, in this context, to imply that unorthodox medicine could never be scientific (Vincent and Furnham 1998: 8). 'Modern medicine' and 'conventional medicine' are imprecise in their scope. The former is too narrow, and the latter is overly broad.

Interpretations of the definition of unorthodox medicine also differ, making it difficult to ensure a common understanding. There has been confusion about what such therapies should be called – alternative, complementary, holistic, unorthodox, unconventional, non-scientific which are only some of the many descriptions in the literature (Kelner and Wellman 2000: 4). Some previous terms used to describe unorthodox medicine such as 'fringe medicine' or 'quackery' should be avoided, it has been argued, as they are degrading (Fulder 1996: 4). There is also confusion about which therapies to include or exclude from the definition of unorthodox medicine and how to classify the multitude of therapies in some coherent way. Kelner and Wellman claim that as the field of pluralistic medicine continues to develop to achieve a clear definition of unorthodox medicine is like struggling to hit a moving target (Kelner and Wellman 2000: 4).

In the Western social science literature, two terms seem to dominate the field: 'alternative' and 'complementary' or the conjunction of these terms 'complementary and alternative medicine' (CAM). As Fulder argues, the definitions of unorthodox medicine as 'alternative' medicine simply reflect the actual state of affairs in the medical field in the Western societies, as it focuses on the one aspect that is common for all unorthodox therapies: the fact that they are separate from conventional biomedicine (Fulder 1996: 4). Saks defines alternative medicine as including those therapies that are not typically supported by the state through research funding and inclusion in education and training programmes for orthodox health professions (Saks 2003a: 3). Moreover, Fulder points out that the term 'alternative' is often used in social research, 'for although the [alternative] therapies cannot replace conventional medicine as a whole, they do so at times for many people' (Fulder 1996: 4). It is worth noting that the term 'alternative' medicine seems to be more popular among American scholars (see, amongst others, O'Connor 1995; Collinge 1996).



The term 'alternative medicine' has been used for all therapies that were found outside of the medical mainstream and had been marginalised by orthodox practitioners. Fulder notes that it will probably become increasingly difficult to define these therapies by their difference from orthodox medicine, as the 1990s have brought the blurring of boundaries between orthodox and unorthodox medical systems (Fulder 1996: 4-5). As the processes of integration of orthodox and unorthodox medicine grew stronger, the name 'complementary' was conceived by some social researchers as more preferable as 'it implies that the therapies are seen as supplements to orthodox medical treatment that enhance and strengthen the overall care offered to sick people' (Vincent and Furnham 1998: 7). Saks, however, states that the term 'complementary medicine' may omit therapies such as homoeopathy that are based on philosophical principles fundamentally opposed to those of biomedical orthodoxy (Saks 2003a: 4).

Some social researchers have avoided the choice between the terms 'alternative' and 'complementary', uniting them into 'complementary and alternative medicine' (CAM) (Fulder 1996; Cant and Sharma 1996a; Kelner and Wellman 2000; Welsh *et al.* 2004). CAM is also traditionally defined in 'political terms' as therapies distinct from current medical orthodoxy. Kelner and Wellman, for example, quoting the resolution of the Office of Alternative Medicine which defined and described CAM politically, state that CAM includes practices other than those intrinsic to the dominant health system, although they insist that the definition of CAM should avoid negative connotations and treat both conventional medicine and CAM on an equal footing (Office of Alternative Medicine 1997: 50, quoted in Kelner and Wellman 2000: 4):

'Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompass all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the political dominant health system of a particular society or culture in a given historical period. CAM includes all such practises and ideas self-defined by users as preventing illness and promoting well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed'.

To summarise what has been argued so far, it is possible to state that the terms 'alternative', 'complementary' and 'complementary and alternative' medicine are often used as synonyms in the social scientific literature, defining therapies found outside of



the medical mainstream. For the research in the thesis, however, the term ‘alternative medicine’ has been chosen. It seems to be more useful for the following reasons. First, it accentuates the ‘political marginality’ of therapies (Saks 2003a: 3), and as it will be shown, unorthodox approaches still receive limited support from the Russian state and have restrictions imposed on their practice. Second, the term ‘alternative medicine’ is broader, as it unites a wider spectrum of therapies in comparison to the term ‘complementary’ medicine which unites only those therapies which are seen as supplements to orthodox medical treatment. Thus, it is argued that the term ‘alternative medicine’ will be more useful in the thesis, where the social standing of orthodox and unorthodox Russian practitioners is compared. Following Saks, biomedical and other therapies that enjoy political legitimacy in this thesis will be defined as ‘orthodox medicine’ (Saks 2003a: 3).

These ‘politicised’ definitions of orthodox and alternative medicine are useful. However, they may be defined as a ‘residual’ type of definition (Kelner and Wellman 2000: 5), as they do not shed light on the essentialist medicinal nature of the phenomena by using a negative approach: by saying that darkness is not light we do not get a complete understanding of what darkness is (Burr 1995). The following section searches for those characteristics of orthodox and alternative medicine which separate them in relation to their knowledge-base, underlying philosophies and approaches to treatment.

## **1.2. ‘Essentialist’ definition of orthodox and alternative medicine**

### **1.2.1. Defining orthodox and alternative medicine as a form of knowledge base**

Orthodox medicine has for long made natural science its cognitive base (Larson 1977: 165; Morgan, Calnan and Manning 1985: 116). Medicine grew out of natural science, based on the principal that the world consists of discrete materials obeying knowable natural laws, which can be used technically to improve life (Fulder 1996: 7). And, as O’Connor claims, in so far as science is seen as successful and prestigious, orthodox medicine enjoys the approval, cooperation, and protection of the legal system and other supporting social institutions: government licensing and regulatory bodies, third-party payment systems, preferred access to federal and private research monies, high prestige and social status and their concomitant benefits (O’Connor 1995: 5). By contrast, all



other health systems are unofficial, and can be described as discriminated against in terms of the aforementioned social support structures.

As O'Connor states, 'science is idealised as possessing clarity of viewpoint and an unimpeachable rigor of method that inherently surmount cultural values and an interest-group bias' (O'Connor 1995: 5). Scientific knowledge and process of inquiry are generally portrayed as genuinely objective and value free, whereas science and its members are deeply believed by many to have the capacity to provide certifiable knowledge composed only of straightforward distillations of raw and refined facts (Wright and Treacher 1978). Doctors are socialised into a scientific culture which makes an absolute distinction between their own systematised knowledge and the knowledge of medicine held by the 'lay' person (Sharma 1995: 121). MacEoin argues that there are understandable reasons why doctors stress the rigid dichotomy between 'science' and 'non-science' (MacEoin 1990: 16):

'Most medical students and many qualified doctors share with Muslims and Calvinists a deep need for their systems to be the truth. Studying medicine is no fun. It is very hard work, with the terror of failure [...] Nobody invests that much of themselves in something without needing very badly the conviction that it is absolutely true and anything else a delusion, that is a worthy vocation and any other is a waste of one's best opportunities'.

The position of rigid dichotomy between 'science' and 'non-science' has achieved intellectual dominance throughout the modern Western culture, and science and their related enterprises have acquired unsurpassed cultural authority. This claim, however, has not gone uncontested (Lock and Gordon 1988; MacEoin 1990; O'Connor 1995). As O'Connor (1995: 13-14) argues:

'Although it is now widely accepted as an academic and philosophical principle that knowledge is constructed, and that all systems of knowledge and belief are culturally situated and shaped, it is still the case from within any belief systems that its proponents view it as a description of the way things *are*, and recognise it as 'right'.

Thus, the term 'scientific' has taken on an evaluative function, meaning 'better' and 'more reliable'. In contrast, 'non-scientific' has come to mean inferiority or unreliability, and to function as critique. Barnes and Edge claim that experimental

science is widely regarded as the final arbiter of truth, functioning as a source of cognitive authority. Not only does it provide knowledge and competence, it is required also to evaluate the knowledge-claims and putative competences of those situated beyond its boundaries (Barnes and Edge 1982: 2). They point out that in modern societies, science is near to being *the* source of cognitive authority, as anyone who would be widely believed and trusted as an interpreter of nature needs a 'license' from the scientific community. And many orthodox doctors would say that non-orthodox medical systems should be denied such a licence, as they do not constitute any science at all. However, as Barnes (1975: 100) argues it should be remembered that:

‘The demarcation between scientific and other forms of knowledge or procedure is a matter of cultural practice; it is an actors’ category and not a sociological one’.

In summary, in the thesis, the difference between orthodox and alternative medicine will not be based on the separation of medicine into ‘scientific’ orthodox and ‘non-scientific’ alternative medicine. Following Kuhn, the difference between orthodox and alternative medicine will be seen as paradigmatic (Kuhn 1962: 149). Paradigm is defined by him as a whole way of thinking and working which filters what researchers are likely to find acceptable or unacceptable in new work or in other traditions: ‘the proponents of different paradigms practise their trade in different worlds’ (Kuhn 1962: 149). As has been argued in the previous chapter, the advance of science is discontinuous and not unilinear and differences between paradigms are never resolved intellectually, as they look at the same phenomenon from the point of view of radically different conceptual frameworks. Although it is important to mention that there has been convergence with orthodox medicine within some alternative disciplines, notably osteopathy, and there are medical doctors who are ready to accept the practices of some systems even if they cannot endorse their theories (Sharma 1995).

### **1.2.2. Defining orthodox and alternative medicine in terms of underlying philosophy, and their approach towards illness and patient**

Trying to distinguish between orthodox and alternative medicine in relation to their approaches to treatment through discriminating traits, different social scientific researchers have taken diverse perspectives as a starting point. All sociological contributions can be roughly subdivided into three categories, according to the subject



of their attention. The characteristic features of orthodox and alternative medicine are mainly differentiated in relation to (1) the approach towards illness, (2) their underlying philosophy and (3) the approach towards patients. Thus, some social researchers analysed orthodox and alternative considerations of what illness is and what are the main techniques for diagnostics and treatment (Inglis and West 1983; Aakster 1986; Stanway 1986; Vincent and Furnham 1998). It has been argued that orthodox medicine is characterised by organ-specific measurements, the technical approach, and the accent upon material standardised treatment, as well as more incisive stronger remedies (Aakster 1986). Alternative medicine, as Aakster argues, in contrast, is oriented towards the whole person context, influences upon several systems of the internal, also psychology and energetic and relies on milder adjustive remedies (Aakster 1986)<sup>4</sup>. Moreover as Fulder claims, orthodox and alternative medicine are different in terms of their areas of competence: the former deals with acute, traumatic, infectious, genetic, and tropical diseases, whereas the latter deals with chronic, psychosomatic, early-stage, non-specific, multi-origin, musculoskeletal, and immunological diseases (Fulder 1996: 6).

Other social researchers have considered the underlying philosophies and beliefs of alternative and orthodox therapies (Muranov 1983; Korolkov 1979; O'Connor 1995; Saks 1996). O'Connor, for example, defines alternative medicine as based on alternative *belief system* with distinctive views of the body, of health, and of the causes of illness (O'Connor 1995: 16). It has been argued that the concept of 'holism' has been central to the alternative belief system and its philosophy. Holism can be defined as responding to the person as a whole (body, mind, spirit) within the context of his environment (family, culture and ecology) (Saks 1997b: 196). This is in contrast to orthodox medicine, where the body has been the predominant focus; and it is treated as though it is divisible into parts that can be repaired if they break down (Saks 1997b: 199). Moreover, Vincent and Furnham argue that the philosophy of alternative therapies is usually based on a general all-encompassing theory of disease, such as, for example, energy imbalance; whereas orthodox medicine has a highly specific, organ bound theories of disease (Vincent and Furnham 1998: 21). McKee, in turn, claims that alternative practitioners are more health-centred. They see health as a positive stance, not merely as the absence of disease (McKee 1988: 780). And alternative therapies attempt, in varying degrees, to recruit the

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<sup>4</sup> This approach towards alternative medicine can be defined as ideological. As it will be further discussed, most differences are differences of degree, not differences of kind.

self-healing capacities of the body (Fulder 1996). They amplify natural recuperative processes and augment the energy upon which the health of a patient depends, helping to adapt harmoniously to the surroundings; whereas orthodox approach is more illness-centred, in the sense that the most important goal is that the illness has to be removed (Neumivakin and Neumivakina 2000; 2001).

Still other social researchers have examined the difference in the perception of the role of the patient (see, amongst other, McKee 1988). For orthodox medicine, doctor/patient relationships are defined as secondary in interest and the patient is seen as passive and dependent, whereas alternative medicine is seen as person-centred care, and the relationship between the client and the practitioner are conceived as open, equal, and reciprocal.

The summary of the major differences is given in Table 2.1:



**Table 2.1: The characteristic features of orthodox and alternative medicine: the approach towards illness, patient and the underlying philosophy**

		Orthodox medicine	Alternative medicine
I L L N E S S	Ultimate goal	Removal of sickness: working against symptoms (Fulder 1996)	Restoration of health: working with symptoms (Fulder 1996)
	Diagnostics and Treatment	Organ-specific measurements, technical approach, accent upon material (Aakster 1986)	Whole person context, influence upon several systems of the internal, also psychology and energetic (Aakster 1986; Anohin 1998)
	Remedies	More incisive stronger remedies (Aakster 1986)	Mild adjustive remedies (Aakster 1986)
	Principle of treatment	Standardised treatment	Individuality
	Areas of competence	Acute, traumatic, infectious, genetic, tropical (Fulder 1996)	Chronic, psychosomatic, early-stage, non-specific/ multiorigin, musculoskeletal, immunological (Fulder 1996)
P A T I E N T	Doctor-patient relationship	Secondary in interest, detached concern (Aakster 1986)	Often of prime interest, education of the patient (Aakster 1986)
	Patient's behaviour	Passive, dependant (Aakster 1986)	Active, partner, responsible (Aakster 1986)
P H I L O S O P H Y	Focus of work	Illness-centred: the illness has to be removed (Neumivakin and Neumivakina 2001)	Health-centred: the health has to be restored, though some symptoms could remain (Neumivakin and Neumivakina 2001)
	Theory of disease	Highly specific theories of disease: organ-bound. (Vincent and Furnham 1998)	A general all-encompassing theory of disease: e.g. energy imbalance. (Vincent and Furnham 1998)
	Doctor's approach	The body is the predominant focus; it is treated as though it is divisible into parts that can be repaired if they break down (Saks 1997b)	Responding to the person as a whole (body, mind, spirit) within the context of his environment (family, culture and ecology) (Vincent and Furnham 1998)

In the above-mentioned list of characteristic traits of orthodox and alternative medicine, most of the differences are, probably, differences of degree not differences of kind. To work out a comprehensible 'essentialist' definition of orthodox and alternative medicine these characteristics should be subdivided into the inseparable and the derivative (Creswell 1994: 85). It may be argued that 'the philosophy of medicine' can be defined as a derivative characteristic. The differences in the underlying philosophies of alternative medicine and orthodox medicine are very important, however, they are rather difficult to capture, as they relate to the Weber's ideal types involving the highest level of abstraction (Weber 1949: 90):

'An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasised viewpoints into a unified analytical construct...In its conceptual purity, this mental construct . . . cannot be found empirically anywhere in reality'.

Thus, Weber argued that the theoretical concepts differ in the level of their abstraction, and when the analysed concepts are very general, they involve the most difficulties in reproducing the concrete reality and doing full justice to the infinite diversity of particular phenomena.

The problems that the analysis of general concepts involves are reflected in the application of the concept of 'holism' which is often used to summarise the philosophical peculiarities of alternative medical philosophy. Under holistic medicine, as has been argued, social scientists understand 'the involvement of the whole person in the promotion of health and the prevention of illness – in which the interplay of mind, spirit and body is perceived within the wider social context' (Saks 1997a: 196). The notion of holism was derived from Jan Christian Smuts (1870-1950), a South African philosopher and statesman, and was taken as a counter to the reductionism of Western natural scientific thought (Gordon 1988: 47). However, as Saks claims, the concept of 'holism', conveying the health-centred approach to the person as a whole, has appeared to be a problematic definition when applied in practice. Some alternative systems do provide fundamental curative treatment (e.g. naturopathy), while others can at times be highly symptomatic (e.g. acupuncture, massage) (Saks 1992a: 7). Another problem,



particularly, with Russian alternative therapies, as will be shown later in the chapter, is that some of them are integrated into the biomedical health sector, and as a result they often do not live up to the ideal of holistic medicine, as they turn into quasi-scientific and reductionist approaches. Thus, in practice the philosophy of different alternative therapies can be diffused and discrete. Holism can be considered as a property of the theory or philosophy underling alternative medicine, however, as Fulder argues, holism is by no means the exclusive domain of alternative practitioners, and it is often hard to draw definite boundaries around alternative medicine (Fulder 1996: 7):

‘There is an overlapping with [orthodox] medicine, in the sense that all good medicine is in a way similar. A good doctor will relate to his patient holistically and diagnose intuitively, sometimes employing conservative treatments that rely on self-healing abilities’.

Thus, holism can be seen as an ideology, which has helped to unite the field of alternative medicine, but the idea which is not always translated into reality (Saks 1997a: 207). What distinguishing traits remain for the construction of the ‘essentialist’ definition of alternative medicine and orthodox medicine? The active or passive role of the patient, for example, would also be excluded as a derivative characteristic. In practice, the clinical manner and approach of individual alternative and orthodox therapists probably varies considerably. Beyond doubt, a good orthodox practitioner will encourage a patient to be active, may also enquire about emotional problems where it is relevant; whereas a poor alternative doctor will see the relationship with a patient as a secondary concern.

The only tangible characteristics, in the author’s view, which are left are those connected with the diagnostics and treatment of illness. As regards to the definition of alternative medicine, one of the good examples of definitions based on the medical specificity of alternative approaches is probably that of Fulder (1996: xv):

‘Alternative medicine – is the aggregate of diagnostic and therapeutic practices and systems which are separate from conventional scientific medicine. They are *usually less interventionist and technical and make more use of self-healing capacities*’ (emphasis added).

This definition, however, suffers from an important omission which could also help to separate almost all known alternative therapies from orthodox medicine: the concept of

influence of alternative medicine on the whole person context, namely influence upon several internal systems. This characteristic is chosen as the central constituent of alternative medicine in the theory of functional systems of the body of a prominent Russian Professor of Medicine Anohin (1998: 315). He has argued that the totality of the internal unites organs and conjunctive tissues in such a way that one organ shares in the work of various bodily systems. The reaction of the body towards environmental influence is reflected in the changes of various bodily systems. Under alternative medicine he understood that type of medicine which was oriented towards treatment of the 'aggregate of the internal' and relied on 'qualitative' multi-organ diagnostics instead of organ-bound specific 'quantitative' measurements. Summing up the above mentioned characteristics relating to the diagnostics and treatment of illnesses, in this thesis the author will use the following 'essentialist' definition of alternative medicine:

Alternative medicine is the aggregate of diagnostic and therapeutic practices and systems which usually exert influence upon the whole person, namely affect several systems of the internal with the purpose of health restoration by mild adjusting medical intervention through making more use of the self-healing capacities of the body.

As regards to orthodox medicine, it will be defined in the thesis as follows:

Orthodox medicine is the aggregate of diagnostic and therapeutic concepts and practices which adhere to the use of drugs and surgery and employ organ-specific measurements, technical approach, and make accent upon material standardised treatment.

To conclude, the author has opted to define orthodox and alternative medicine in the above-mentioned way, while recognising that these definitions are still not entirely satisfactory, as there are variations and gradations in the nature of orthodox and alternative medicine. These definitions will be taken as lying on a continuum, where the 'ideal type' alternative and orthodox therapies will be the two extreme poles, whereas real orthodox and alternative practises will be located in between the polarised positions. These 'essentialist' definitions, however, are important, as they make possible cross-cultural comparisons, accentuating that the nature of orthodox and alternative medicine in industrialised countries is broadly similar.



## **2. Unorthodox therapies in Russia: difficulties in the search for a collective name and definition**

In Russia, as in other industrialised countries, there is a single ‘official’ authorised and authoritative health care and medical culture (Davis 1989; Field 2000). The sanctioned medical practices and institutions are backed by considerable social and political powers (Field 1995; 2000). Similar to Western medicine, among the values of Russian official health care is ‘the singular prestige accorded to science and its associated professions, and the sanction of formal education and academically legitimated research procedures (with a strong emphasis on scientific experimentation) as the primary – if not sole – valid means of knowledge’ (O’Connor 1995: 4). Russian orthodoxy, similar to most of its European counterparts, includes all forms of health care that are significantly supported by the state; it is based on biomedicine and largely centred on the use of drugs and surgery (Davis 1989: 233-240).

As it will be shown in the later chapters, ‘alternative medicine’ appeared in the Soviet period, when Russian indigenous therapies were excluded from official health care even though they still latently existed in the practice of some orthodox practitioners and in the hands of lay rural practitioners. This latent existence prompted the development of alternative medicine in the post-Soviet period. To date, alternative medicine in Russia is diverse in nature, including practices from acupuncture and aromatherapy to herbalism and homoeopathy. Russian alternative therapies are not typically supported by the state through research funding and inclusion in education and training programmes for orthodox health professions. However, due to the growing public demand, the position of alternative medicine has changed to a certain degree (see the further detail in Chapters VI and VII). The following analysis serves as a background to provide necessary terms and definitions used in Russia for understanding the revival and professionalisation tendencies of contemporary alternative medicine discussed in the ensuing chapters.

### **2.1. The official collective name of unorthodox therapies and their definition**

The post-Soviet revival of the Russian traditional indigenous therapies and the introduction of foreign alternative approaches such as Chinese acupuncture and others resulted in the need for a collective term defining diverse unorthodox therapies. On



August 2, 1989 the Ministry of Health held a heated debate about a possible term which would unite the therapies separate from those supported by the state (Karpeev and Kiseleva 2002: 8). The ministerial authorities recalled all the terms that had been used in different countries. Eventually, the Ministry of Health adopted the collective term 'traditional medicine' suggested by the World Health Organisation. Traditional medicine was defined by World Health Organisation (1978) as:

'The sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental and social imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing'.

The Ministry of Health suggested that the term 'traditional' would stand for all therapies that are separate from orthodox biomedicine, despite the fact that some therapies are simple like hydrotherapy. Others are sophisticated like Ayurveda and still others are based on the latest technical achievements like laser-acupuncture (Vasilenko 2002: 1). This is in contrast to Western countries, where 'traditional medicine' is a designation that only partly overlaps unorthodox medicine, as it is usually applied to indigenous, non-conventional healing practices, including folk and village medicine (Fulder 1996: 109-10). Since then, the Russian official term 'traditional medicine' has embraced approximately the same scope of therapies, which in the European Union countries and America are united under the terms 'alternative' or 'complementary'. According to the law, the following 'traditional' therapies can be practised in Russia: (1) acupuncture; (2) homoeopathy; (3) manual medicine (osteopathy)<sup>5</sup>; (4) medical massage; (5) naturotherapy (aromatherapy, etc.); (6) traditional/folk medicine (apiotherapy, hirudotherapy, hydrotherapy, herbalism) (Karpeev and Kiseleva 2002: 125-28).

As distinct from Britain, all of the above-mentioned unorthodox techniques were allowed to be practised only by medically qualified doctors and were considered the treatment of choice (Ministry of Health 1998). The lay unqualified practitioners were confined to the private sector, where in contrast to Britain, they have practised illegally, with the exception of so-called folk healers: that is those who may prove that they have a special gift for healing or that their knowledge in traditional medicine such as bone-

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<sup>5</sup> In Russia, the accepted term for osteopathy is 'manual medicine', which covers a wider range of manipulations than Western osteopathy does. However, Russian and Western osteopathic techniques are broadly similar, therefore this author shall adhere to the term 'osteopathy'.



setting, herbalism or other traditional therapy was inherited from their ancestors (State Duma 1993b). In this context, the authorities of the Ministry of Health realised that the definition of 'traditional medicine' coined by WHO was not unconditionally applicable to Russia (World Health Organisation 1996), as it mainly referred to ways of protecting and restoring health which existed before the arrival of modern biomedicine and which are exclusively practical. In 2000, the authorities of the Ministry of Health slightly modified the definition of 'traditional medicine' to accentuate the fact that some 'traditional' therapies might be scientifically proved and might have a logical explanation (Kiseleva *et al* 2000: 53):

'Traditional medicine is the aggregate of attainments and skills based on practice and observation, handed down from generation to generation in oral or in written form, *which might have no scientific or logical explanation*, used in the processes of prevention, diagnostics, treatment of illnesses and rehabilitation. Traditional medicine is an integral part of the official health sector of the Russian Federation, and traditional therapies should be considered medical practice' (emphasis added).

This definition of unorthodox medicine remains ideological, as it appeals to the dichotomy of 'scientifically-based' orthodox medicine and 'non-scientific' unorthodox medicine. Similar to Western countries, this dichotomy has achieved intellectual dominance, and science and orthodox medicine have acquired unsurpassed cultural authority. This definition is also subject to criticism, as it proclaims that unorthodox medicine is an integral part of the official health sector, whereas in fact the principles of integration of traditional and orthodox medicine remain a slogan. As has been said, unorthodox medicine is discriminated against in terms of research and the extent to which it is excluded from the curriculum of medical institutions. In addition, as against orthodox medicine, unorthodox therapies are not free at the point of access, with the exception of acupuncture and osteopathy which are free for some categories of patients. Thus, from a social scientific point of view, the term 'alternative' seems to define the social position of unorthodox medicine in Russia more precisely. Below, the reaction of Russian unorthodox practitioners towards different terms defining unorthodox medicine will be analysed.

## 2.2. Terminological confusions on the phenomenological level and in the professional sphere

The adoption of the collective name 'traditional' for unorthodox therapies by the Ministry of Health of Russian Federation did not settle the issue of terminology. This term had been used on two levels: on the phenomenological everyday level and within the medical professional sphere. The contentious nature of the term 'traditional' is reflected in the fact that both Russian common people and orthodox doctors no longer conceive even of the ancient traditional medical therapies such as herbalism or hirudotherapy as 'traditional'; that is to say nothing about recently borrowed unorthodox therapies, like acupuncture and osteopathy, which are still considered to be exotic. The therapies separate from orthodox biomedicine are commonly called 'non-traditional', 'non-conventional' or sometimes 'folk medicine', whereas the term 'traditional' or 'conventional' is often related to the modern medicine taught in the higher medical institutions. The terms 'alternative' and 'complementary' are not used by common people or medical practitioners; unless they happen to know that these terms are accepted in the West.

In research carried out for the thesis, the author interviewed nineteen prominent Russian unorthodox practitioners on alternative medicine. The interviews included a question on what collective term for unorthodox therapies they thought was more useful and why this was so. (The methodology of research and the results will be analysed in detail in Chapters IV, VI and VII). Most participants of the research came to the conclusion that the discussion of terms existing in the sphere of unorthodox medicine was important. A few interviewees called to mind the Russian saying: 'a great ship needs the right name', however, participants in the research were not unanimous about what was 'the right' collective name for existing unorthodox therapies. It is interesting that the majority favoured the established term 'traditional' out of the terms: 'alternative', 'traditional', 'complementary' and 'holistic'.

Most unorthodox practitioners explained that they would prefer the established term 'traditional medicine' to maintain the existing *status quo* and to enhance further their position. They thought that the change of name, especially into 'alternative medicine', might threaten hard-won more or less stable position within the official health care



sector. Participants of the research pointed out that the introduction of the term 'alternative' in Russia promoted nowadays by the World Health Organisation might aggravate the relations between orthodox and non-orthodox practitioners (Karpeev interview 2003<sup>6</sup>). As one of the participants of the research claimed:

'The introduction of the term 'alternative' from which some of the Western countries have refused will lead to the opposition of the two streams of medicine. Traditional medicine has become a part of the Russian official health care sector. Renaming us into 'alternatives' will bring us back to the position of medical outcasts' (Sitel interview 2003).

This parallels the situation in Britain, as in the last decade practitioners of many unorthodox therapies have become less willing to be seen as providing an alternative to orthodox medical care (Vincent and Furnham 1998: 7). They believe that they can work alongside doctors as independent practitioners with specialist knowledge. Most Russian participants in the research admitted that their approach towards illness and patients was different from the approach of orthodox practitioners. They, however, believed that they did not exclude each other but rather complemented the other. This was especially true for osteopaths and acupuncturists. They argued that modern osteopaths and acupuncturists were not alien to orthodox medicine, as most of them had come out of it. In Russia, the adoption of almost all unorthodox practices had from the very beginning been within the official state health system, where medically-qualified doctors started practising them, and almost did not produce a new generation of lay unorthodox practitioners. The head of the Society of Acupuncturists commented:

'We have always been quite close with the orthodoxy. You can see that we are not alternatives for a few reasons. We understand the importance of the research. Our students are motivated to defend PhD theses in orthodox medicine and to use their orthodox knowledge in acupuncture. We issue a journal on acupuncture which is scientifically-based' (Vasilenko interview 2003).

Moreover, the interviewees pointed out that they themselves and the members of their families did not abandon orthodox medicine. The head of the All-Russia Homeopathic Association argued: 'If one has appendicitis, prescription of homoeopathy would not be only absurd, it would be criminal negligence' (Zamarenin interview 2003). These

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<sup>6</sup> Here and further in the text, interview references are given in Appendix 3.

unorthodox practitioners understood and warned their patients that acute, infectious illnesses and cases which demanded surgical intervention should be dealt by the orthodox medical practitioners.

The term 'complementary' received a warmer welcome from the Russian unorthodox practitioners, especially from those who strived for integration into the official health care sector. These respondents argued that the term 'complementary' was appropriate, as it implied the integration of two medical approaches. The desire to be included into the orthodox professional nomenclature was rather strong on the part of some practitioners (see chapter VII in detail). Some respondents, however, were not ready for an integration into official medicine on non-equal terms and emphasised the deficiency of the term 'complementary'. They said that 'complementary' was not a suitable definition as many therapies were 'principal' and self-sufficient; thereby they did not require cooperation with the medical orthodoxy. Quite a few unorthodox practitioners in the research, mostly homeopaths, osteopaths, acupuncturists and healers, considered their medical knowledge and practical skills to be sufficient for a wide range of illnesses.

In the opinion of the interviewees, the established term 'traditional medicine' was the best out of the various terms suggested for discussion. However, they said that it also had few drawbacks. One of the problems had to do with the fact that the unification of practical indigenous medicine and scientifically-based high technology therapies could not be justified. Thus, for example, Russian medically qualified acupuncturists who used the latest technological know-how of orthodox medicine, such as laser innovation, quantum wave information theory and therapies, fell into the same group as 'healers' (Vasilenko 2002: 4). Besides, it was claimed that some of the methods were not traditional to Russia, such as Chinese acupuncture, Indian Ayurveda, or they had originated in Germany, like homoeopathy.

Many participants in the research argued that the term 'holistic' medicine could have become a good substitute for the term 'traditional medicine', if the name had not been discredited by the 'quacks' – that is, those practitioners who had little or no knowledge of medicine or of the therapy they practised, and who often called themselves 'holistic healers'. The participants in the research lamented that their therapists could not be



united under the term 'holistic' which would point to their inner characteristics of treating patients as a whole, influencing several systems of the body, instead of accentuating the durability of their practices or its experimental/non-scientific character, which is unjustifiable and degrading. One of the participants of the research commented that he was going to publish an article on the successes of acupuncture in the country and planned to title it 'Back to Holism in Acupuncture'. However, he had to change the title taking into consideration the modern negative connotation of the term 'holism' (Vasilenko interview 2003):

'Holism is a very good old Russian word and it highlights the essence of the so-called alternative therapists. However, the healers of the 1980s compromised it, as all those who claimed to treat illnesses of all kinds called themselves healers. And now health users no longer trust the word 'holistic medicine'.

In summary, the collective name 'traditional medicine' preferred by the participants in the research does not seem to be wholly justifiable in the context of modern Russia, as the ancient indigenous folk therapies no longer make up the core of unorthodox medicine. There are major unorthodox systems of medical knowledge loaned from other cultures, such as Chinese acupuncture (borrowed in 1957), Indian Ayurveda (borrowed in the 1980s) and German homoeopathy (adopted in the 1870s; banned in 1938 and reborn in the 1980s). Moreover, as has been argued, even indigenous Russian therapies are no longer seen as 'traditional' by common people and medical practitioners. And the term 'traditional medicine' seems to mask the politics of the authorities of the Ministry of Health, who having defined the therapies as 'traditional medicine' and 'integrated medicine', still marginalise them. The position of unorthodox practitioners to maintain the existing *status quo* using the established term 'traditional medicine' is understandable. A social scientific researcher, however, may take the role of assessing the situation as an external observer. And, consequently, in the thesis preference will still be given to the term 'alternative medicine', which defines the social position of unorthodox medicine in Russia more accurately.

### 3. Common characteristics of alternative therapies in contemporary Russia

Alternative medicine so far has been referred as a homogenous phenomenon. However, the concept of alternative medicine in Russia is broadly based, and includes a wide spectrum of therapies. As a result of the 1992 economic and political reforms, the indigenous traditional Russian medicine was replenished by new unorthodox therapies ranging from the fully developed systems of theoretical knowledge such as acupuncture, osteopathy, and Ayurveda to minor therapies such as aromatherapy and colour-therapy. The importance of working out definitions of the main alternative therapies practised on the territory of the Russian Federation was stressed by the Ministry of Health in 2000. The ministerial authorities proclaimed that:

‘The main terms in the sphere of non-conventional medicine are ill-defined and are distinct from the internationally accepted terminology, which brings out misunderstanding and confusion’ (Karpeev and Kiseleva 2002: 8).

On the phenomenological level, there has been no common understanding about what therapies stand separate to orthodox biomedicine either. This is well exemplified by the results of two All-Russian sociological research studies that aimed to investigate the attitude of the users of health service towards unorthodox therapies. In both research studies, respondents to the questionnaire were asked about their attitude towards unorthodox therapies, however, the terms used in the questions were different. In the research conducted by the Institute of Sociology of the Russian Academy of Sciences the respondents to the questionnaire were asked what their attitude towards ‘*folk medicine*’ was (Modern Russian Society in Transition 1998). The survey showed that 73% of the respondents trusted folk medicine; 21% partly trusted it and 5% did not trust it. The other All-Russian social research conducted by the Fund of Public Opinion also aimed at finding out the attitude of the respondents towards unorthodox therapies, however, the question was formulated differently. The respondents were asked whether they trusted ‘*non-traditional medicine*’ with a commentary in brackets: ‘healers, herbalists, extrasensory individuals and others’ (Fund of Public Opinion 2002). The responses were rather negative. Only 10% of the respondents said that they trusted ‘non-traditional medicine’; 70% partly trusted it and about 20% did not trust it at all. The difference in the findings of these two studies may be explained by the fact that the



term 'folk medicine' has a positive connotation and is mainly understood as including herbalism and self-help techniques as cupping, plasters, herbs; while 'non-traditional' is negatively tinged, as closely connected with magic, charms, crystals and amulets.

Within Anglo-American sociology, there have been various attempts to classify and categorise alternative therapies (Pietroni 1995; O'Connor 1995; Fulder 1996; Kelner and Wellman 2000; Welsh *et al.* 2004). It may be argued that some Western classifications of alternative therapies are applicable to Russian alternative medicine, although, as Kelner and Wellman claim, all classifications of alternative medicine are subject to change, according to clinical, cultural, political and economic developments (Kelner and Wellman 2000: 6). To date, using the classification of Pietroni (1986), the following approaches in Western and in Russian alternative medicine can be distinguished:

- Psychological approaches and self-help exercises, such as breathing, and relaxation, meditation, exercise regimes and visualisation.
- Specific therapeutic methods, such as massage, reflexology, aromatherapy and spiritual healing.
- Diagnostic methods, such as iridology, kinesiology and hair analysis.
- Complete systems of healing, such as acupuncture, herbal medicine, osteopathy, chiropractic, homoeopathy and naturopathy.

This classification is useful as it clearly distinguishes 'psychological approaches and self-help exercises' which are usually practised in the 'popular' sector (Kleinman 1980; 1993), which excludes professionals and lay non-medically qualified practitioners. It includes several levels: individual, family, social network, and community beliefs and activities. Thus, 'psychological approaches and self-help exercises' were excluded from the research for this thesis, as the community beliefs and community self-help healing practices are beyond the scope of the research. The above-discussed classification of Pietroni, however, is not flawless, as the criteria of separation of therapies into 'specific therapeutic methods' and 'complete systems of healing' are not well defined. According to Pietroni, 'complete systems of healing' are those offering distinct approaches to the diagnosis and treatment of a wide range of complaints and disorders, and are the most developed in terms of philosophy, research and 'professional' status (Pietroni 1986). In contrast, specific therapeutic methods are often allied to a particular philosophy but lack the development of the systems that underlie acupuncture, homeopathy and so on. Thus,



the criteria of separation remain ambiguous. It is unclear, why, for example, spiritual healing is deprived of the status of a 'complete system of healing', whereas 'naturopathy' has been granted it.

Alternative therapies, undoubtedly, can be separated into privileged and underprivileged in terms of public acceptance and the extent of legitimacy. Their social standing, however, is not always connected with the fact of whether they are developed in terms of philosophy or research. Thus, the classification of alternative therapies developed by Kelner and Wellman seems to be more heuristic than Peitroni's, as they do not estimate therapies in terms of the scope of development of treatment techniques, philosophy and undertaken research, instead they separate them in terms of the scope of their legitimacy and public acceptance based on empirical research (Kelner and Wellman 2000: 6):

- top of the social hierarchy (osteopathy, chiropractic and acupuncture);
- middle range of the social hierarchy (naturopathy and homoeopathy);
- bottom of the social hierarchy (rebirthing and Reiki).

As further analysis will show, this classification is applicable to Russia, where all alternative therapies can be separated into the above-mentioned three categories. The top of the social hierarchy is occupied by new alternative therapies, borrowed from other countries, such as acupuncture, osteopathy, and homoeopathy. As it will be discussed in the ensuing chapters, these therapies received the greatest support from the Ministry of Health. They had mostly been concentrated in the hands of medically qualified practitioners, as the Ministry of Health tried to increase the supply of doctors with knowledge of alternative medicine to oust lay alternative practitioners from the medical market. Acupuncture and osteopathy were included into the list of medical specialties (Ministry of Health 1997).

The middle range of the social hierarchy is occupied by indigenous 'traditional' Russian therapies. They did not receive a corresponding support from the Ministry of Health, as they were largely practised by lay alternative practitioners<sup>7</sup>. However, indigenous 'traditional' therapies have been trusted by the majority of the Russian population (Modern Russian Society in Transition 1998). People tend to use them as additional complementary supplements to orthodox medicine. And 'healing' is localised at the

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<sup>7</sup> Lay practitioners started to represent a real threat to the hegemony of medical profession at the end of the 1980s, as the demand for them came from the majority of population, including the elite groups (see details in Chapter VI).



bottom of the social hierarchy. It is forbidden by the Ministry of Health and distrusted by the majority of population (Fund of Public Opinion 2002).

Another classification suggested by Kelner and Wellman arranges alternative therapies according to the context in which they are delivered (Kelner and Wellman 2000: 6):

- ‘clinical forms’ (chiropractic, homoeopathy, acupuncture and naturopathy);
- ‘psychological/behavioural forms’ (yoga, dance therapy, and biofeedback);
- ‘social/community forms’ (faith healing and folk medicine).

As has been argued, in the thesis only ‘clinical’ and ‘social/community’ forms will be considered. The main questions addressed in the thesis have to do with the professionalisation of alternative services, and not with self-help techniques, as in Russia, all ‘psychological/behavioural forms’ are confined to the popular self-help sector. Moreover, all of the therapies that were distinguished as occupying the top of the social hierarchy – acupuncture, osteopathy, and homoeopathy – can be referred to ‘clinical forms’ and are practised by doctors. Therapies that occupy lower positions in the social hierarchy, indigenous ‘traditional’ Russian therapies, including healing, can be referred both to ‘social/community’ and ‘clinical therapies’, as they are practised by both medically-qualified and non-medically qualified practitioners.

A further well-known typology of alternative medicine was developed by Fulder (Fulder 1996: 125). He distinguished between the following categories: (1) ethnic medical systems (acupuncture, Chinese medicine and Ayurveda), (2) manual therapies (chiropractic, reflexology and massage therapy), (3) therapies for mind/body (hypnotherapy, psychic healing and radionics), (4) nature-cure therapies (naturotherapy and hygienic methods), and (5) non-allopathic medical systems (homoeopathy and herbalism). This classification gives an idea of what therapies are popular in Western countries. However, it is fraught with logical errors, as most of the above-mentioned categories overlap, for example, ‘nature-cure’, ‘non-allopathic’ and ‘ethnic medical systems’. Herbalism, for example, can be included into all of these subgroups. Fulder’s definition was developed with the purpose of presenting the most popular therapies in the West; however, it is not applicable to other countries, as the integrative categories are not well defined and are intertwining.

### **3.1. Glossary and short history of the main alternative therapies used in Russia**

Contemporary Russian alternative therapies are described in the two following sections. Indigenous ‘traditional’ Russian therapies (middle of the social hierarchy) are discussed in the first section. Alternative therapies, borrowed from other countries (top of the social hierarchy) are presented in the second section. The foregoing lists of alternative therapies are not comprehensive: they contain only those alternative therapies which are allowed for practice in Russia, with the exception of Indo-Tibetan medicine which is forbidden. Nevertheless, it is widely practised in some regions and the question of its legal status is raised. The therapies are listed not in terms of importance as their significance and popularity is different in different Russian regions. For simplicity, they are listed in alphabetical order. The definitions have been derived from the following sources: Fulder (1996: xv-xxiii), Karpeev and Kiseleva (2002: 120-50), Kiseleva *et al.* (2000: 42-57); Saks (1997a: 205), Sharma (1995: 218-23); Sitel (2003: 1-7), Vasilenko (2002: 1-3), Vincent and Furnham (1998: 9-16).

These sections also describe major Russian alternative therapies and give definitions, related to the main stages of their development. It is shown that Russian alternative medicine existed latently within the official health state sector even during the Soviet period. This covert existence of alternative approaches has had an impact on the post-Soviet development of alternative medicine. In the Soviet period, alternative medicine was seen as an interesting and important object of investigation, though the interest towards it seldom went beyond research as it was not incorporated into the practice of medical practitioners. The Soviet state was mostly concerned with research in indigenous traditional Russian therapies: herbalism, apiotherapy, hirudotherapy, and Indo-Tibetan medicine

#### **3.1.1. Indigenous ‘traditional’ Russian therapies**

Contemporary indigenous traditional Russian medicine incorporates: apiotherapy (the appliance of bees and the use of products of their vital activity); healing (the direct transmission (marshalling) of psychic energy for therapeutic purposes); herbalism (the use of plants to prevent and treat illness), hirudotherapy (the use of medicinal leeches and the products of their vital functions) and Indo-Tibetan medicine (the aggregate of



diagnostic and therapeutic practices, based on the Vedic texts). These therapies are described in detail as follows:

## **Apiotherapy**

Apiotherapy (from Lat. 'apitherapia', where 'apis' – 'bee') is a special method of treatment based on the appliance of bees – bees sting through acupuncture points – and the use of products of their vital activities, such as honey, wax, etc (Ludansky 1991: 6). Bee-keeping (apiculture) was already famous in the old days Russia. The first mentioning of the abundance of honey and early beekeepers in the country were in the works of Nestor, the eleventh century writer and chronicler. The first medical manual that had the section on the appliance of bees and the usage of honey and wax for medicinal purposes was written in 1672 (Ludansky 1991). Ludansky claims that the therapy was especially popular in Russia in the eighteenth and nineteenth centuries. Apiotherapy was not forbidden during the Soviet period, though its practice was not widely spread. A few scientific-research institutes were involved in the study of apiotherapy and several PhD theses were defended on the subject of the use of bees for medicinal purposes (Ludansky 1991: 4). Any Soviet doctor could research apiotherapy in Moscow; however, there were few conditions under which they could practise it. The situation changed in 1989, when the Scientific Council for Bee-Keeping and Apiotherapy was founded under the auspices of the State Committee of Science and Engineering within the Ministry of the USSR (Ludansky 1991: 9). It legalised the therapy and strengthened its social standing. Since then, apiotherapy has spread in both 'clinical' and 'social/ community' forms, although its popularity could never compare with healing.

## **Healing**

Healing can be defined as the direct transmission (marshalling) of psychic energy for therapeutic purposes (Fulder 1996: xviii). Healing can occur at a distance or by the laying-on of hands (auric healing), based on the transmission of energy to the client or the marshalling of the subject energies for therapeutic purposes. This may or may not be associated with particular religious beliefs. In Russia, the approach is binominal: the term 'healing' is colloquial, the terms 'energoinformation' or 'bioenergetics' are

seemingly scientific and preferred by healers. The main difference between Russian and Western healers lies in the claim of the former to the scientific base: mostly new age physics, new physiology and biology (Savin 1995; Shipov 1997; Zenin *et al.* 1998). Healers in Russia mainly belong to religious sects, though they try to take advantage of the popularity of the Orthodox religion: they use the Orthodox Church rituals and symbols (Grigoryan 2002: 31). Healing had its origins in Russia at the time of shamans and was forbidden by the Church in the tenth century. However, it is still practised and is very popular nowadays, although it is confined to the 'social/community' sector. Only 'folk healers' can practise it, those practitioners who may prove that they have a special gift for 'healing' (State Duma 1993b). In the past, Russian healing and herbalism were closely intertwined, however, nowadays, these therapies are distinct. Herbalism enjoys a higher social standing among orthodox practitioners, as it is more associated with science and research.

## Herbalism

Herbalism can be defined as therapeutic use of herbal substances (Sharma 1995: 220). The system of herbal medicine is based on a pharmacopoeia which is more ancient than that of biomedicine. Herbalism in Russia started to develop in the primitive communal societies and has always been used on the self-help basis by the Russians. The number of plants used in medicinal purposes all around the world is approximately equal to 20.000, while Russian herbalism numbers about 2.000 herbs and plants (Korsun *et al.* 1999: 10). Russian orthodox pharmacopoeia has authorised only about 127 herbs and orthodox doctors use about 300 (Kovaleva 1993: 130). Russia historically has been in the lead as far as the usage of natural remedies goes. Kovaleva states that in 1913 Russia stored up about 39.000 tons of herbal substances, and about 29.000 tons were exported (Kovaleva 1993: 130). Unfortunately, this market position was lost during the Soviet period. For example, in 1995, the country stocked only 5.300 tons of herbal substances (Korsun *et al.* 1999: 11). Herbs were not excluded from the Soviet biomedical system and were seen as a valuable resource for a people in a difficult economic situation. Moreover, there was a widely diffused faith in the herbs among Russian population, which for generations have had herbal treatment for common conditions. Hirudotherapy was as popular as herbalism in the eighteenth and nineteenth century. However, it lost its popularity in the Soviet period.



## **Hirudotherapy**

Hirudotherapy or Bdelotomy (from Lat. 'hirudo' – leech; 'bdellometer' – 'artificial leech') refers to the use of medicinal leeches and the products of their vital functions (Baskakova 1998). One of the main methods of 'hirudotherapy' is 'hirudoacupuncture' – treating of separate organs and systems of the body through acupuncture points with the help of the medicinal leech (Gerashenko and Nikonov 2004). The method was known and used in the past in Russia. The blossoming of hirudotherapy came in the eighteenth and nineteenth centuries, when the population of the country used more than 30 million leeches per year (Baskakova 1998: 27). At the time, the export of leeches was as important to the tsarist government as the export of grain. The famous Russian doctor Pirogov, who began the process of professionalisation of Russian doctors, wrote that during the period of the Crimean war (1853-1856) he himself applied about 100 or 200 leeches daily (Baskakova 1998: 30). As against apiotherapy, PhD theses on hirudotherapy have not yet been defended in Russia. However, hirudotherapy was more widely practised during the Soviet period. In 1928, a centre 'Medical Leech' was opened in Moscow, which organised training courses on hirudotherapy for doctors with various qualifications. During the period since 1930 to 1935, the centre treated over 10.000 patients and provided the basis for wide clinical research (Baskakova 1998). Since then, hirudotherapy has been practised in 'clinical' and 'social/community' forms by both doctors and lay practitioners. One of the advantages of hirudotherapy is that it can be easily mastered, in comparison, for example, to Indo-Tibetan medicine.

## **Indo-Tibetan medicine**

Indo-Tibetan medicine originated in India and was close to Ayrvedic medicine – the aggregate of diagnostic and therapeutic practices, based on the Vedic texts, incorporating a complete life instruction and branches on constitutional medicine, surgery, remedies, and longevity practices (Kiseleva *et al.* 2000: 51). In Russia the interest in Eastern medicine grew strong only at the end of the eighteenth century. Until then it had been locally bound to the places where lived the ethnic minorities – the Buryats and the Kalmyks – whose culture and in fact geographical position were close to the traditional Eastern countries, where the traditional medicine was cultivated for thousand years (Kiseleva *et al.* 2000: 11). Mostly, the method was practised by Buddhist lamas. The earliest written reference about the Tibetan medicine was in 1853

in the city of Chita where the Tibetan therapies were widely used during the typhus epidemic. The successful treatment of a then famous lama Badmaev led to special decree of Alexander III who gave him the permission to treat patients in the Army hospital under the supervision of Russian doctors. The younger brother of Badmaev, who already got the higher education in St-Petersburg, did several translations of the Indian and other country books on the Tibetan medicine in 1887-1893. In the Soviet period, a few research groups were organised to study Eastern medicine (Kiseleva *et al.* 2000: 29). Karpeev and Kiseleva write that in 1936, the Research Medical Institute which specialised in Eastern medicine was opened in St. Petersburg. Since then, Soviet and Russian scientists have been mainly concerned with the investigation of the Chinese and Indo-Tibetan medicine, the widened international relations with India later in the century resulted in diffused Ayurveda research (Karpeev and Kiseleva 2002: 50). Indo-Tibetan medicine has not yet been legalised. However, the authorities of Ministry of Health promised to legalise it in the nearest future (*Moskovsky Novosti* 2004) Despite the fact the Indo-Tibetan medicine is indigenous for some Russian regions, in terms of legitimacy, it lags behind some 'foreign' alternative therapies introduced in the twentieth century.

### **3.1.2. New 'foreign' alternative therapies**

New alternative therapies came to Russia not earlier than the end of the nineteenth century. The oldest among them is homoeopathy. Homoeopathy entered the Russian Empire with physicians of foreign, mostly German origin in 1821, and very quickly, by 1827-28, attracted the interest of higher circles in St. Petersburg, including the royal family (Karpeev and Kiseleva 2002: 79). Acupuncture came to Russia in 1957 and osteopathy in 1983.

### **Acupuncture**

Acupuncture – the technique whereby needles are inserted into the body at certain special zones for prevention and treating diseases and disabilities (Vasilenko 2002: 1). In Russia, the term acupuncture is used rarely, as the accepted term is 'reflexotherapy'. However, it should not be mistaken for reflexology (the therapeutic massage of the feet), as happened in Fulder's book (1996: 107). Italy and Russia are the only European



countries that use the term 'reflexotherapy'. However the techniques used are not at variance with the practice accepted in the Western countries. In this thesis, the term 'acupuncture' will be used in order to avoid confusion. There are more than thirty types of acupuncture in the modern world (Karpeev and Kiseleva 2002: 125). The most popular types of acupuncture in Russia, besides, the traditional needle one are the following:

- (1) laser acupuncture and electro-acupuncture (electrical or laser currents are applied to needles inserted into the acupuncture points),
- (2) acupressure or shiatsu (finger massage applied to the acupuncture points),
- (3) apio-acupunctura (bees applied to the acupuncture points);
- (4) hirudo-acupuncture (leeches applied to the acupuncture points).
- (5) moxibustion (the burning of rolled cones of dried mugwort over acupuncture point).

Moxibustion is only practised by lay practitioners in Russia, is very rare and is forbidden.

Acupuncture arrived in Russia much later than in most European countries. The method initially developed in China and spread out to other Eastern countries like Korea and Japan and by the seventeenth century from the Orient to parts of Europe (Saks 1997a: 198). In Russia, it was adopted at the time of the Soviet-Chinese friendship, after the civil war in China (1946-1949) where Russian doctors assisted the fighters for the establishment of the Chinese People's Republic. Russian doctors took up acupuncture which was practised by Chinese laymen and, having returned, some of them started to practise acupuncture illegally. The Ministry of Health obtained information about the efficacy of the treatment, and in 1957 sent prominent scientists, mostly professors, to China to master the method (Kiseleva *et al.* 2000: 17). Acupuncture has been practised in the Soviet period on a very limited basis under the control of the Ministry of Health. Specialists were taught in two laboratories in Moscow and St-Petersburg (Tabeeva 1980: 59). In 1976, the Ministry of Health opened the Institute of Acupuncture (Reflexotherapy), which has qualified thousands of acupuncturists (Vasilenko 2002: 2). Today acupuncture is studied in twenty-five Russian cities on the refresher courses and in different scientific and practical centres (Kiseleva *et al.* 2000: 17, 18). The level of research and practical experience in the sphere resulted in the state registration as a medical specialty (Ministry of Health 1997). Other Chinese therapies, however, did not attract attention of the medical practitioners and researchers and were not registered by the Ministry of Health. Consequently they are prohibited.



## Homoeopathy

Homoeopathy is a therapeutic system developed by Samuel Hahneman, which treats the symptoms of a patient with diluted microscopic doses of those remedies which create similar symptoms in the healthy: 'like cures like' (Kotok 2001: 18). The therapy was developed in the 1790s onwards. The theory and main principles of homoeopathy can be found in Hahnemann's books *Organon* (1810), *Chronic Diseases* (1828), and *Materia Medica Pura* (1811-1819); Hahnemann's followers further developed the concepts. Homoeopathy is a well-elaborated method and widely practised in Russia (Kiseleva *et al.* 2000: 52). In Western countries homoeopathy is also used in Anthroposophical medicine, a therapeutic system based on the teachings of Rudolf Steiner in which physical health is achieved through harmony between the various coexistent aspects of man and the environment. Anthroposophical medicine, although forbidden in Russia, is practised by some lay practitioners (Kiseleva *et al.* 2000: 52). Interestingly, anthroposophical remedies together with homoeopathic remedies are allowed for sale in all Russian pharmacies and reckoned over-the-counter drugs (Kiseleva *et al.* 2000: 52). Homoeopathy is mainly practised by medically-qualified practitioners and is almost as popular as osteopathy among health consumers and medical practitioners (Karpeev and Kiseleva 2002: 47).

## Manual medicine and osteopathy

Manual medicine in Russian stands for 'osteopathy', although the techniques used by Russian manual doctors are somewhat at variance with the practice of Western osteopaths. In Russia, manual medicine is understood as a form of manipulation of the spinal and other joints in which movement and function of the musculoskeletal system is restored based on both means of leverage, repeated manual articulation and stimulating the nervous system (Sitel 2003: 1). As distinct from Russian manual medicine, Western osteopathy is more concerned with the muscle and joints ignoring the nervous system (Sitel interview 2003; Samoroukov interview 2003). Further, Russian manual medicine draws on some chiropractic techniques related to the use of sharp, short, thrusting pressure on the spine alongside classical osteopathic techniques of rhythmical and gentler pressure on the whole body including the spine (Sitel 2003: 2). Thus, as distinct from Western osteopathy, Russian manual medicine includes a wider range of manipulation. This difference is partly connected with the fact that



osteopathy in Russia was taken over from Eastern Europe (Czechoslovakia mainly). Moreover, Russian manual medicine drew on traditional Russian bone-setting which was closer to chiropractic than osteopathy.

In 2000, the Western version of osteopathy taught by the American and Western European teachers was for the first time introduced in St-Petersburg. To date the osteopaths trained in the West number about a hundred, whereas traditional Russian manual therapists number about 10.000 practitioners. The two techniques adopted from Eastern and Western Europe will be considered together, as therapies based on manual manipulation, although the practitioners themselves are adamant that there are important differences in technique and theory. In the thesis the term 'osteopathy' will refer to Russian 'manual medicine' in order to avoid misinterpretation. Similar to acupuncture, osteopathy was registered as a medical specialty in 1997 (Ministry of Health of the Russian Federation 1997). Chiropractic is partly integrated into Russian osteopathy, although the law forbids independent practice of chiropractors.

## **Naturopathy**

Naturopathy is a collective term in Russia for a number of practices which use predominantly the body's own self-healing capacities, concentrating on diet, self-care, and life-habits (Neumivakin and Neumivakina 2001: 4). In Russia the term unites those practices which mostly use remedies of natural origin: herbs, minerals, organic remedies (like tissues, enzymes, extracts and biological material), water, oils, etc. In the West naturopathy is almost always multidisciplinary in nature (Collinge 1996). The Russian practitioners mostly stick to one method and they would not know that they practise 'naturopathy', as the term is still alien to the Russian language, though it is quite apt as it unites various techniques such as mineral remedies (salts and inorganic materials taken as remedies); aromatherapy (external use of essential oils from plants for massage or inhalation); hydrotherapy (the use of water as a therapy as in taking health-giving baths and drinking spa water). Naturotherapy has not yet been widely disseminated among medically qualified doctors and, as a result, is less popular than the above-discussed acupuncture, homoeopathy and osteopathy.

## **Conclusion**

The chapter has outlined the definitions of medicine existing in the Anglo-American and Russian social scientific literature in order to elaborate the definitions of orthodox and alternative medicine, which will be used in the thesis. The rationale for the adoption of the terms 'orthodox' and 'alternative medicine' has been explained, as well as the choice of their 'politicised' and 'essentialist' definitions. The chapter has also provided a glossary and short history of the main alternative therapies currently used in Russia. It gave an overview of all therapies that are officially allowed for practice in the country. These therapies have been subdivided into categories in terms of their legitimacy and public acceptance. The purpose of this chapter was to specify differences of alternative and orthodox medicine in terms of approaches to treatment and in terms of their position in the wider social context. This provided a background for a historical analysis of the professionalisation of medicine in Russia presented in the following chapter.



### **III. A HISTORICAL ANALYSIS OF THE DEVELOPMENT OF MEDICINE IN RUSSIA**

In the previous chapter, the existing confusion in definitions of alternative and orthodox medicine were analysed and the definitions, which will be used in the thesis, were elaborated. It has been shown that Russian medical orthodoxy, similar to other industrialised countries, is based on biomedicine and largely centred on the use of drugs and surgery. Orthodox medicine was defined as including all forms of health care that receive significant support from the state (Saks 2003a: 2). Alternative medicine, conversely, was defined as including those therapies that were not typically supported by the state through research funding and inclusion in education and training programmes for the orthodox health professions (Saks 2003a: 3). Moreover, as against orthodox medicine, Russian alternative medicine, except acupuncture and osteopathy, is not free for patients at the point of access. It has also been suggested that alternative therapies are more diverse in nature, spanning from acupuncture and homoeopathy to healing and naturopathy. As regards the diagnosis and treatment of illnesses, alternative therapies usually attempt to treat the whole person. They affect several systems of the body with the purpose of health restoration by mild adjusting intervention through making more use of the self-healing capacities of the body (Aakster 1993; Fulder 1996; Anohin 1998; Saks 2003a).

This chapter aims at providing a balanced account of the development of health care in Russia that considers both orthodox and unorthodox medicine on equal terms. As Saks argues, ‘orthodox and unorthodox medicine should be seen as two sides of the same coin. They both deal with human health and... their health care histories are intimately intertwined’ (Saks 2003c: 53). The chapter avoids the one-sided narratives, which generally focus on either orthodox or alternative medicine, in some cases as if the two were entirely separate spheres. It examines both sides of the health care coin from a neo-Weberian perspective with a particular emphasis on the theme of professionalisation. The period taken for analysis is broad, starting from the ninth century, the period of the formation of the Russian state, and concluding with the end of the twentieth century, the end of the Soviet period. The main focus is on the following periods of the development of medicine in Russia:

1. Medicine prior to 'professionalisation'. The golden age of Russian traditional medicine (from the ninth century to the late sixteenth century);
2. 'Professionalisation from above' of doctors with university education. Peaceful co-existence of 'professional' and 'non-professional' medicine (from the seventeenth to the mid-nineteenth century);
3. 'Professionalisation from within' of medical practitioners. Medicine is divided into 'orthodox' and 'unorthodox' (from the mid-nineteenth to the beginning of the twentieth century);
4. 'Deprofessionalisation' of medicine and the politics of the Soviet state. The triumph of biomedicine (from the beginning of the twentieth century until the demise of the Soviet power)

The first part of this chapter shows the earliest patterns of traditional medicine in pagan Russia, followed by the period when the Church became the main regulating body of medical affairs. The second part provides a foundation for understanding of the growth of the medical profession in the period when the monarchy was the driving force for its development. It explores the history of 'professionalisation from above' of the medical profession during the three hundred years prior to the mid-nineteenth century, when subordination to the tsarist government, bureaucracy and academic credentialling became fused as a major characteristic of the Russian image of the medical profession. The profession became a mixed group consisting of relatively prestigious, quasi-aristocratic, foreign doctors and relatively low status Russian physicians. It shows that early 'professional' medicine of university-trained doctors was closely intertwined with traditional medicine. The third part introduces the 'professionalisation from within' of the Russian physicians from the mid-nineteenth century. It shows the transformation of the medical profession into a more homogenous, relatively independent and powerful corporate body. During the period of intensive formation of professional organisations, there was a growth of the group ideology and a drive for social closure in the early twentieth century. The fourth part considers the actions of the Soviet regime taken to implement biomedicine and at the same time to limit the power of the medical profession and it highlights the transformation of the profession into a group of disparate state employees and private practitioners.

The historical development of medicine in Europe is already well covered in the literature and will be referred to only briefly to illuminate the differences with the



evolution of the medical profession in Russia (Johnson 1972; Waddington 1984; Abbott 1988; Siegrist 1990; Porter 1997). The mainstream concepts of the interface between orthodox and non-orthodox practitioners in Britain are also outlined in the chapter, where the differences or similarities are apparent in relation to Russian history (Stacey 1988; Bakx 1991; Cant and Sharma 1996a; Kelner *et al.* 2000; Saks 2003a).

## **1. Medicine in Russia before the professionalisation of the medical profession: from the ninth century to the late-sixteenth century**

The incidence of particular diseases varies between cultures, and different cultures interpret and treat illness differently. All societies have distinct ‘disease-theory systems’ to identify, classify, and explain illness and these ‘disease-theory systems’ change over time (Foster 1976; Young 1982; Pelto and Pelto 1989; Pilch 1993). However, an influential medical anthropologist Foster offers a comprehensive model of basic theories of the causation of diseases that enables a cross-cultural comparison of health care systems (Foster 1976: 775-776). He views medicine as a cultural system, in the same sense that language, kinship, and religion are cultural systems. Therefore, a single component of illness and health cannot be properly understood without being interpreted in, and by, the health care system in which it is embedded. Thus, according to Foster, there are ‘personalistic’ and ‘naturalistic’ disease theories. Avoiding the term supernatural, Foster uses the term ‘personalistic’ in order to articulate non-Western causality. Personalistic disease theories blame illness on sorcerers, witches, ghosts, or ancestral spirits. The term points to the active and purposeful intervention of an agent. In contrast to ‘personalistic’, he uses ‘naturalistic’ to refer to the disturbance of equilibrium in impersonal terms, such as hot/cold or Ying/Yang (Foster 1976: 775). Personalistic health care system views illness as a special case among various misfortunes, whereas naturalistic system is restricted to illness. Naturalistic disease theories, including scientific medicine, explain illness in impersonal systemic terms (Foster 1976: 776).

Shweder and colleagues suggest a broadly similar classification of casual agents of a disease, although they use three kinds of modes, namely ‘interpersonal’, ‘moral’, and ‘biomedical’ modes of causal explanation (Shweder *et al.* 1997: 127-129). This distinction is based on moral responsibility. The ‘interpersonal’ model views illness as

an instance of victimisation of the ill will of an agent, similar to the 'personalistic' model of Fulder. According to the 'moral' mode, illness is a consequence of the past transgression of a sufferer. The 'biomedical' mode understands illness as a material event in moral neutrality, which is similar to Foster's 'naturalistic' model, although Shweder's 'biomedical' concept is narrower, as it does not include other explanations of the disturbance of equilibrium in impersonal terms, such as hot/cold. The authors acknowledge that these three modes do not exist exclusively, but can be attached to each other.

In the subsequent analysis of the early patterns of medicine in Russia, the classification of Foster of 'personalistic' and 'naturalistic' medicine is taken as a basis and it is extended with 'moral' model of Shweder and colleagues. All these three types of casual explanations of diseases are applicable to the Russia health care in different historical context.

### **1.1. The earliest patterns of 'personalistic' medicine in pagan Russia**

All societies have health-care systems – beliefs, customs, and specialists concerned with ensuring health and preventing and curing illness. In the old days, the tribes which lived on the territory of modern Russia, saw illness as having personalistic causes. The communal culture of primitive tribes was regulated by shamans, who kept traditions, executed rituals and rendered primitive medical assistance (Sokolov and Stepanov 2001). Personalistic medicine and rituals were inseparable. Early medical men drew on occult and practical techniques which constituted their expertise. A vivid example of such combined functions is the hierarchy of idols in pagan Russia, who according to the folklore supervised both the spiritual life of the people and their health (Rusmann 1996: 10-12). Each idol was responsible for certain functions of the body, and 'demanded' believers to follow a certain type of medical treatment, food habits and rituals. The main god was named Perun, after him came two other gods: 'Belee' symbolising male energy and 'Golden Mother' symbolising – female energy, similar to the Chinese doctrine of 'Ying' and 'Yang', although as distinct from China, not only the male and female energies were involved in peoples' health regulation.



There were also many minor idols, which supervised the nervous system, regulated the balance of hormones, the acid balance, and the muscular system (Sokolov and Stepanov 2001). The multitude of idols helped the heathen priests and early medical men to explain illness by constant quarrels and fights between the idols, which brought about the imbalance of various bodily systems. Rituals were important but not sufficient for the restoration of health. The medical men prescribed herbal treatment, diets, and certain exercises. Each idol was in favour of certain herbs, which patients had to take to placate him/her. The idols' 'tastes' were quite changeable: at a certain time of the year, the idols (corresponding to the various bodily systems) changed their tastes for, say, winter or summer herbs.

This pagan 'personalistic' system of medical treatment played an important role in pre-Christianity Russia (until 998 A.D.). It gave birth to a widely diffused faith in herbalism among the Russian population, which for many generations has used herbal treatment for common conditions (Kovaleva 1993). Christianity supported the development of herbalism and other traditional medicines that appeared centuries later. However, the Orthodox Church insisted that medicine should lose its mystical scheme of interpretation.

## **1.2. The introduction of 'moral' medicine: the Church as the main regulating body of medical affairs from the tenth to the sixteenth century**

Christianity introduced a new 'moral' understanding of illness and medicine. The pagan believers saw illness as the violation of the normal functioning of the body brought about by the malevolent idols. For the Christians illness became the norm of human life, an important sign that there is an imbalance of the proper harmony of body, soul and the Holy Spirit caused by sin (Zhohov 2003: 62). The dysfunction of the body was seen as a result of the breaking of the rules of New Covenant. Illness was no longer seen as an 'enemy'. It became an 'assistant' that informed people of their inner imperfections (Grigoryan 2002: 12-13). Health problems passed into the shared charge of the Church and medicine men (Zobern 2003: 7). For the Christians, the harmony of soul and body could be reached only within the Church, as distinct from the Eastern religious philosophies, where medical men were seen as helpmates in the process of putting into balance of mind, body and soul. The Orthodox Church, on the contrary, forbade

practices that claimed to penetrate into the inner world of the patient – healing, witchcraft, magic and the rituals related to herbalism. The health restoration was supposed to start through the Church attendance and participation in devotions such as confession, communion, unction, and others (Grigoryan 2002: 16). The treatment of the body was never repudiated. Medical men, however, were not supposed to go beyond the normalisation of the bodily functions.

The time before the twelfth century was the period of the active growth of the new forms of Russian empirically-based folk medicine. Apiotherapy (appliance of bees and use of the products of their vital activities), hirudotherapy (appliance of leeches and use of the products of their vital activities) and bone-setting occupied a fitting place. The only Eastern therapy that was practised in the old-days in Russia was Tibetan medicine that came to the Asian parts of Russia with the dissemination of Buddhism, that originated in India in the fifth century B.C, and Indian medicine became the basis for its formation (Kiseleva *et al.* 2000: 51). The Russian version of Indo-Tibetan medicine also drew on Chinese medicine (mainly, acupuncture), Persian and Nepal medicine and the folk therapies of the Mediterranean countries (Sokolov and Stepanov 2001: 15). It should be noted that some Russian folk practitioners relied on ‘moral’ causal explanations of disease, while others still referred to ‘personalistic’ causes.

Christianity aimed at a rapid conversion of the pagan world, but the process went rather slowly. The Tatar-Mongol invasion was a yoke that lasted for about three centuries (1234-1480), and it impeded the propagation of Christianity as well as the further development of folk medicine. This period was characterised by stagnation of cultural life, the revival of which occurred only in the fifteenth century. After the liberation, the Church resumed the struggle against the remnants of paganism and personalistic medicine – the use of charms, amulets and witchcraft. Most herbs, herbal tinctures, mineral and animal remedies were also disgraced as they were often used in pagan rituals. However, early lay medical practitioners wrote books on the intricacies of folk medicine, copying and disseminating them secretly, as there was a risk to be found guilty of practising magic and being a witch or a sorcerer. The first written copies of the ‘herbal books’ appeared in the early sixteenth century (Literature Memorials of the Ancient Russia 1987: 77). The archival collection of the folk books on herbal treatment of those old days numbers about four hundred books (Zabilin 1992: 13).



The Church stopped persecuting these interpretations and home literature on herbalism and other folk therapies developed at the end of the sixteenth century, when early medicine regulation passed into the hands of the tsar and the tsarist government (Rihter 1820), the Church was left with superintending hospitals attached to monasteries.

## **2. Medical practitioners and the tsarist state: ‘professionalisation from above’ from the seventeenth to the mid-nineteenth century**

Kleinman suggests a model that subdivides any health care system into three sectors: the ‘popular’, ‘professional’ and ‘folk’ sector (Kleinman 1980: 50-59). The popular sector of health care refers to the lay, non-professional, and non-specialist arena. It includes several levels: individual, family, social network, and community beliefs and activities. The folk sector is characterised as the sector of the non-professional and non-bureaucratic specialists. The professional sector comprises the organised healing profession. Each sector has its own system of explanation, or what he calls an ‘explanatory model’. This answers questions about the nature of an illness, such as its etiology, time and mode of onset of symptoms, pathophysiology, course of sickness like the degree of severity and the type of sick role, and treatment (Kleinman 1980: 105).

Using Kleinman’s model (Kleinman 1980; 1993), it is possible to say that by the end of sixteenth century, Russian medicine could be subdivided into two sectors, namely a ‘popular’ sector of self-help practices and a ‘folk’ sector of lay practitioners of traditional Russian medicine. As has been shown, their explanatory models had been personalistic and moral. The employment of the first foreign doctors with university education paved the way for the development of the ‘professional’ sector of medicine, which relied more on ‘naturalistic’ explanations for the causation of disease. Diseases were explained in more impersonal systematic terms and did not necessarily refer to moral causes.

It is important to mention that in the beginning of the seventeenth century, medicine could hardly be regarded as ‘professional’ scientific or ‘non-professional’ unscientific. Foreign doctors, graduates from the universities, may have used some of the tools and rhetoric of science but that did not make their knowledge-system theoretically and empirically powerful, comprehensive, systematic, experimentally testable and predictive

(Squires 1985: 4). Aside from early scientific knowledge, the first foreign doctors could make poisons, claimed to foretell the future, had knowledge of astrology, and used traditional blood-lettings, leeches and herbal remedies (Rihter 1820; Mirsky 1996).

## **2.1 Origin of the ‘professional’ sector of medicine: high status foreign university-trained doctors**

In all modern industrialised societies the professions and the state have developed in a highly interdependent manner (Johnson 1972; Saks 1995a; Moran 1999). In Britain the classical professions of medicine and law established their autonomy as specialist occupations with the Crown patronage in the early seventeenth century, when the Royal College of Physicians was formed. In the latter half of the eighteenth and nineteenth centuries they were established as self-regulating associations, and thereby defined and circumscribed the role of the liberal state (Saks 1995a). Nowadays the British state in its renewed form has engaged in a different type of relationship with professional bodies, which have begun to lose the position of dominance (Fulder 1996; Moran 1999; Saks 2000b). However, the independence of the medical profession from the state has always remained more pronounced in Britain than in Russia, where autocratic rulers incorporated the professional services into the state and defined them as a state service (Mirsky 1996).

In Russia, the modern medical profession was largely brought into being by demand from the traditional aristocracy. The precursors of today’s scientific medical practitioners were invited from abroad by Ivan the Terrible (1547-1584) (Mirsky 1996: 15). At first, the privilege of having a professionally trained doctor became accessible just for the tsar’s family. Since the early seventeenth century, the tsar allowed invitations to foreign practitioners from the nobility. Until then, the Russian nobility and gentry as well as the common people had been treated only by specialists in indigenous folk medicine. The relations between the Russian government and the foreign medical professionals, using Johnson’s terminology, were those of patronage, that is, the dominant effective source of demand for occupational services came from a small, powerful, unitary clientele (Johnson 1972: 65). Johnson argued that oligarchic patronage was characteristic of traditional aristocratic societies such as, for example, seventeenth- and eighteenth-century England, where the gentry and merchant class monopolised professional services.



Under a patronage system, recruitment into the profession is based on sponsorship (Johnson 1972: 66-7). In Russia, the major criterion for evaluation of the first foreign practitioners was the university education they had received in their home countries, where entry to the university depended upon a classical education and an appropriate social status. The first foreign medical practitioners were of undeniable distinction. Most of them held Master's and Doctor's degrees in medicine, and they often came with the recommendations from the royal courts of England, France, Germany, Netherlands and other countries. Foreigners dominated the quasi-professional sector of the health field in Russia for the whole of the seventeenth century. In 1654, the first Russian scientific medical school was opened (Zobern 2003: 7). However, the number of Russian doctors outgrew the number of overseas specialists only at the beginning of the nineteenth century.

The tsarist regime did not ignore the health needs of the nobility and gentry in the countryside and military men. Control over their health care was entrusted to a special government department, the Aptekarskii Prikaz, which was organised at the end of the sixteenth century (Mirsky 1996). The state and the university-trained medical practitioners became closely linked through the overlapping membership of the Aptekarskii Prikaz. This department was staffed with the foreign doctors invited by the government and headed by a representative of the Russian gentry appointed by the Tsar. From 1716, the tsar started to choose the head of the health care department from among the medical practitioners (Mirsky 1996: 67).

Mirsky argues that the state in those early years did not try to subordinate medical practitioners to civil servants (Mirsky 1996). Control over the exams to qualify as a doctor, entry into the profession and later on, a system of medical education, was shared between the state and medical practitioners. Despite the very limited applicability of 'professional' medicine among university-trained doctors, they secured a distinct elevated status. Foreign university-trained doctors and apothecaries enjoyed the support of the government, although, as Johnson argued, the authority of the profession under patronage may have been undermined by their powerful clientele (Johnson 1972: 68). Foreign doctors had high income and prestige and they were rather independent as far as professional decision-making was concerned. In many Western countries, the situation was quite the opposite. In England, for example, even by the first half of the nineteenth century, the predecessors of the contemporary medical profession – apothecaries,



surgeons and physicians – did not enjoy state support and did not stand out among a broad span of other practitioners with whom they competed on equal terms in the market-place (Porter 1997). Although the Royal College of Physicians was established in the sixteenth century, it was locally bound and the fragmentation of the medical authorities could not enforce even the limited restrictions in relation to both insiders and outsiders (Waddington 1984).

In Russia the university-trained doctors, members of the Aptekarskii Prikaz, became responsible for control over entry to the profession. While the first foreign physicians and apothecaries were trusted on the basis of recommendations from the noble people in their home countries, the succeeding medical specialists had to take examinations to prove their special skills and expertise. The workers of the Aptekarskii Prikaz determined the content of the exams and played the role of examiners (Rihter 1820). Doctors were also in charge of the formation of a library of scientific books in medicine and other related sciences. Moreover, the members of the profession together with the representatives of the gentry became responsible for the supervision of the work of pharmacies and hospitals. Furthermore, the professionals were put in charge of the training of other medical workers. In 1654, the Aptekarskii Prikaz opened the first medical school which worked for a few decades and prepared one hundred ‘Russian lekars’ and fourteen bone-setters (Mirsky 1996: 34). The graduates of the school were termed ‘lekars’ instead of physicians, because they were taught through an apprenticeship and the level of their qualification was close to that of paramedics nowadays. Later in the eighteenth century, the degree of ‘lekar’ became the first scientific degree which Russian medical students could be awarded; the next one was ‘doctor of medicine’ (Dal 1980: 246). In those early years the gap between the social position of the foreign and Russian doctors was tremendous.

Thus, the operation of a patronage system in the seventeenth- and eighteenth-century Russia gave rise to the notion of ‘professional gentlemen’, who were expected to share the values and to some extent the status of their Russian patrons (Johnson 1972: 68). The practitioners invited by Ivan IV had similar respect to that accorded to the nobility: they could dine with the Tsar, were presented with rich houses and some other valuable presents (Rihter 1820). However, as Johnson argues patronage is associated with a fragmented, hierarchical, locally-oriented occupational group (Johnson 1972: 68). The existence of an elite that monopolised an occupation did not eliminate the needs of other



social groups. They were catered for by subordinate occupations (lekars) or in terms of a divergent system of health knowledge – folk traditional medicine.

The wide disparity between the social position of Russian and foreign medical practitioners slightly changed at the end of the seventeenth century with the implementation of the system of medical ranks by the government. The rule of arbitrary salaries was broken: 'In 1681, the salary of the highest ranks of the foreign doctors was fixed at the level of 730 roubles, the lowest ranks – 200-250 roubles, ... the salary of Russian lekars was 25-50 roubles' (Zhuk 1963: 19). However, the existence of poorly paid and lowly qualified lekars and lay practitioners alongside university-trained doctors in the open market led to the phenomenon where practitioners with no university education tried to take advantage of the title of a 'doctor' which provided status and high income. As a consequence, the title of medical practitioners was protected by state action.

## **2.2. State protection of the title of medical profession: doctors distinguished in terms of status**

Mirsky argues that in terms of the scope of its activities, the Aptekarskii Prikaz became the first 'Ministry of Health' and 'Academy of Sciences' in Russia (Mirsky 1996: 46). The employees of this health department and their activities were financed directly from the tsarist treasury. The Aptekarskii Prikaz in Moscow functioned until August 1721, then it was renamed the Medical Chancellory and transferred to St. Petersburg. The new health department, as the previous one, enjoyed a distinct and privileged position among other state departments: it was subordinated directly to the tsarist family. The Senate was subordinated to the tsar and the other state institutions were not allowed to interfere with the work of the Medical Chancellory. A decree proclaimed that: '[The health department] should not report to any state institutions and do not have to obey orders from any of them' (Rihter 1820: 236).

The name of the health department altered, but the functions remained mostly unchanged. Private and public hospitals as well as state and private pharmacists and doctors worked under its jurisdiction. It is important to stress that by the end of seventeenth century a market for university-trained foreign practitioners had started to form. Many noble consumers got medical assistance from the foreign university trained



doctors employed by the Medical Chancellory. However, the number of state university-trained practitioners was limited and some representatives of the nobility and affluent merchants started inviting doctors from abroad on their own. Some foreign physicians also came to Russia without any invitation, searching for employment. The growth of specialists with university education distinguished by the tsar in terms of status and income in the open market was accompanied by the growth of untrained medical practitioners, later referred to as 'charlatans' or 'quacks', those who took advantage of the title and had no university-based medical knowledge.

The health department had to take measures to protect those who used the services of university-trained doctors, even though their numbers were small. The head of the department advanced an initiative to outlaw all unqualified medical practitioners (Chistovich 1870). The Senate supported the suggestion and passed an Act which formally excluded the medically unqualified from the ranks of the medical profession. Thus the orthodox medical profession in Russia obtained a legally underwritten monopoly of title in the eighteenth century, much earlier than its counterparts in Britain<sup>8</sup>. In 1721, an act to register medical practitioners proclaimed that 'Doctors and lekars should not dare to practise unless they have been accredited by the Medical Chancellory' (Shagov 1926: 427). The profession was granted control over a single register: all doctors had to take exams to get an official document of accreditation. This Act underwrote the exclusive rights of doctors over state medical employment. In the market, however, there were still violations of the 1721 Act, because there was a high demand for the services of university-trained doctors. Non-accredited practitioners, mostly foreigners, claimed to be university-trained doctors. So, the head of the health care government department appealed to the Senate with a request to introduce penalties for the breach of the Registration Act. In 1729 and in 1751 the Senate passed new statutes which tightened the accreditation rule (Shagov 1926: 427).

However, even in the nineteenth century there have still been cases where the 1721 Act was ignored in practice. The health department complained on the pages of the professional press about medical 'impostors'. One of the articles exposed a Greek man who had arrived in Moscow and claimed to be a doctor. The health department issued an order: 'To remind him in front of all Moscow doctors, lekars, medical support staff

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<sup>8</sup> In Britain, the Royal College of Physicians got the right to license surgeons and apothecaries from the sixteenth century onwards (Waddington 1984), while qualified practitioners got the legally enshrined right to the title of doctor only following the 1858 Medical Act (Saks 1992a).



and medical students that he must not call himself a doctor or a medical practitioner ... and make him sign for it' (Meditinsky vestnik 1862: 157). It can be argued that as a result of state protection of the title of medical profession the status of medical practitioners increased: they received the exclusive right for state employment, which entailed a guaranteed high income and career opportunities.

### **2.3. Issues related to the self-regulation of medical practitioners**

The Medical Registration Act of 1721 which granted a legally underwritten monopoly of title to the Russian forerunners of the conventional medical profession today did not result in the consequence that the 1858 Medical Act brought about in England (Mirsky 1996). British professional groups on the basis of their legally underwritten monopoly got the greatest freedom to achieve social closure and enhance their status (Waddington 1984). In Russia, the monopoly of title and the controls over a single register – all doctors had to take exams to get an official document of accreditation – brought about the exclusive rights of doctors over state medical employment. The government did not challenge the knowledge of medical practitioners about intricacies of practice and medical expertise. However, health practitioners were granted protection of title without self-regulation. The profession totally depended on the state for improvements in its status, and this slowly deteriorated as the numbers of foreign and Russian practitioners grew. The scope of government control had not diminished with regard to the remuneration of the medical profession and the allocation of money in the health field, as well as the training procedures and the exams necessary to qualify as a doctor. The tsar continued to interfere even with issues of medical ethics, as used to happen before the 1721 Medical Registration Act<sup>9</sup>.

Moreover, one more social institution – the university – started to have an effect on the professional decision-making powers from the eighteenth century. Previously, the arrangements for entry to professional practice were divided between the state and the profession. With the opening and development of medical schools, the academicians started to take control over the content of examinations; the terms, conditions and goals

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<sup>9</sup> Well-known examples of early interference were the following two decrees. In March 1682, the tsar proclaimed that doctors would be executed if their negligence or evil intent had resulted in a death of a patient (Mirsky 1996: 49). The other example has to do with the state implementation of the medical oath in 1682 (Zabludovsky 1981: 80-81).

of education and training. The first higher medical institution for the training of doctors was opened under the regime of Peter the Great (1679-1725) in Moscow in 1706 and was heavily influenced by the Holland medical school (Navarro 1977: 11). It was the first medical institution in the country where education was built on theoretically based practice instead of a craft apprenticeship. During the eighteenth century, medical schools were opened in more than ten hospitals (Chistovich 1883).

## **2.4. Differentiation in the social position of medical practitioners**

### **2.4.1. Segmentation of the medical profession into medical practitioners and medical bureaucrats**

The number of university-trained medical practitioners and medical institutions grew and the monarchy realised the need for growth in its administrative structures. In 1733, so-called 'local' health care departments affiliated to the Medical Chancellory were formed in Moscow and St.-Petersburg, which continued in existence until the mid-nineteenth century (Rihter 1820: 210). These health care departments became the first attempt to decentralise public health care and to increase bureaucratic controls over the profession.

The Medical Chancellory existed until November 1763 and then was replaced by the Medical Board. The scope of functions of a new health care department widened. Above all, the aim of the tsarist resolutions was to control public hospitals for the poor, which had previously been under the superintendence of the church. The new central health care department for the first time was subdivided into two departments: (1) 'the collegium of doctors and lekars' art', which was responsible for scientific and practical medical questions, and (2) the chancellory which dealt with the problems of hospital administration (Mirsky 1996: 125-26). The trend towards the growth of both the numbers of medical practitioners and of the bureaucratic administration of medicine grew stronger at the end of the eighteenth century, when in 1775 the Empress Catherine the Great issued the Province Reform that provided for the systematic extension of professional practitioners and treatment facilities to the provinces (Alexander 1981: 202). This law put the health of the non-serf population in the hands of local health departments. By 1797, all Russian provinces had opened local health care departments,



which were supposed to carry out duties similar to that of the central health care department (Chistovich 1883: 48-49).

The implementation of this system entailed the subordination of medically qualified doctors to the 'medical bureaucrats'. If in the early years, the government was mainly responsible for the regulation of medicine, while the professional issues were left to the practitioners themselves, the state of things changed with the introduction of the local health care departments (Meditsinsky vestnik 1862: 170):

'When local health districts were established the Medical Board did not take into consideration physicians' scientific degrees, and in many places Doctors of Medicine who did not search for the administrative position became subordinated to the [low-qualified] lekars. From that time on 'medical officials' or in other words medical bureaucrats appeared and the Doctors' diploma started to lose its weight. The drive for ranks in the medical hierarchy equated the deepest knowledge with vulgar ignorance'.

Although the issue of the depreciation of medical diplomas in the above mentioned quotation from the nineteenth century period is perhaps overstated, the fact was that the increased bureaucratisation of medical affairs in the eighteenth century led to the upward mobility of the medical officials. If, at the beginning, local health care departments were headed by highly qualified medical practitioners, later on were more often headed by managers with lower qualifications. The status of medical officials in terms of a steady income, a guaranteed pension at the end of the state service and the scope of power resources had increased (Rihter 1820). The standing of medical practitioners, however, depended greatly on the place and type of their employment. Rich clients provided a decent living for the better-qualified foreign medical practitioners. The most disadvantaged groups were those working in the rural areas of the provinces and undertaking army service. These doctors could not get to a rank higher than junior officers and, in comparison with military men, were discriminated against in terms of salary, social and other types of benefits (Semeka 1951: 56).

#### **2.4.2. Differences in social position of city and rural medical practitioners**

Mirsky has stated that institutionalised local health care departments in the regions required more than three hundred doctors and about a thousand secondary medical

practitioners. However, the demand for qualified doctors outstripped the supply (Mirsky 1996: 134). There were two reasons for that: insufficient numbers of medical practitioners and a lack of desire on their part to work in the provinces. The need to increase the number of medical 'recruits' became one of the major concerns of the state. The government tried to enlarge the number of medical practitioners through quite unusual incentives. For example in 1748, Queen Elizabeth made some students from the clerical institutions transfer to the medical schools. In the same year, widows of physicians and pharmacists were informed that they would be given pensions only if they had signed an official agreement that their children would study medicine. Furthermore, in February 1754, the Queen promulgated a law stating that medical practitioners must have a compulsory life-long professional involvement. She forbade doctors to leave their health care posts and choose another career (Rihter 1820: 108).

This ban on the exit from the profession, however, could not make up for the lack of doctors in the provinces. Still, the physicians preferred to stay in large cities where they could get better payment from clients and the government, even though as a result many of them encountered difficulties in gaining employment (Zhuk 1963: 24). This 'surplus' of physicians appeared during the period (1861-1865) when qualified medical help was unavailable for the greater part of the Russian population (Zhuk 1963: 23). The problem of the faulty organisation of the public health system had to be solved by the government in the 1860s. By that time, the medical profession had become a defined area in the social division of labour, although, as has been argued, it could not be regarded as a homogeneous group. Social prestige was allocated differently along the lines of 'foreign/Russian doctors', 'medical bureaucrats/medical practitioners' and 'doctors for the gentry/doctors for the poor'. At the top of the hierarchy there were medical bureaucrats and upper-class foreign or educated abroad Russian physicians with knowledge of Greek medicine serving elite groups, such as the royal family and the aristocracy. However, both elite foreign doctors and less qualified Russian doctors largely used Russian traditional medicine in their practice, as it is discussed further.

## **2.5. Independence and interdependence of professional and traditional medicine**

Health care pluralism was characteristic of most modern Western industrialised countries until the early nineteenth or mid-nineteenth century (Torrance 1987; Saks 2001). Ramsey characterised this period as a 'radically open medical field' where



treatments were offered competitively in a market place by a diverse range of practitioners (Ramsey 1998). It was difficult to clearly differentiate practitioners in relation to the therapies employed and the length and content of their training (Porter 1994). The power of the developing profession over the medically unlicensed was very limited and there was a continuing overlap between the knowledge employed by folk practitioners and that used by medical practitioners of the day (Saks 1996: 30). For example, up to the eighteenth century senior figures in the prestigious Royal College of Physicians in England could engage in such 'unorthodox' practices as astrology (Saks 1996). In Russia, early medical practitioners depended heavily in their practice on the therapies popular among lay specialists, such as herbal treatment, hirudotherapy ('leeches'), bone-setting, apiotherapy ('bees'), and hydrotherapy.

None the less, by the mid-nineteenth century, two distinct types of medical system in Russia had been formed: elite university-trained doctors treated the rich dwellers of Moscow and St. Petersburg and traditional folk therapists dealt with the majority of the country. The historical development of the relations of the precursors of today's orthodox medical profession and non-orthodox practitioners differed from their Anglo-American counterparts. The main difference had to do with the fact that the precursors of today's Russian apothecaries, physicians and surgeons never competed with the traditional folk specialists on equal terms in the open market. The Russian medical profession was largely brought into being by the demand of the traditional aristocracy for treatment of gentlemen by gentlemen and remained the treatment for the rich until the mid-nineteenth century (Larson 1977; 1990). Practitioners with no university education were not seen as rivals to the knowledge of university-trained medical practitioners about the intricacies of practice and medical expertise and they were not admitted to practise within the state health sector. They were dependant on the market demand and on the treatment of the poor. And doctors did not consider village 'wise men and wise women' who provided care for the poor and were specialists in herbs, leeches, charms or amulets to be their rivals.

Moreover, university trained doctors in Russia always used folk medicine as complementary in their day-to-day practice as they were supposed to master and apply the main Russian folk medical therapies, especially herbalism, under the influence of the royal family and other wealthy clients. At the time of 'bedside' medicine, wealthy paying clients influenced the form of both diagnosis and treatment (Johnson 1972). As

one of the first Russian academicians Lepehin (1740-1820) commented, wealthy clients understood that the best remedies in the country were not discovered by doctors with all their theoretical knowledge but were discovered by empirical testing of the common people (Zobern 2003: 8).

As early as the seventeenth century, foreign doctors were encouraged to take up Russian folk therapies by both the tsars and the gentry, and traditional folk medicine became complementary to the early 'scientific' techniques. The issue of dissemination and induction of traditional folk medicine was one of the priorities of the state. Russian tsars have devoted considerable attention to folk medicine, mostly to herbalism. Herbs took the position of official remedies in Russia in the seventeenth century, when the tsar made a decree according to which the Aptekarskii Prikaz was to gather herbs and medicinal plants and produce remedies (Zobern 2003: 7). The foundation of the first medical school in 1654 was followed by one more innovation: the introduction of the 'apothecary gardens', where medicinal herbs, plants and trees were grown. In the eighteenth century, medicinal remedies were grown and collected all over Russia: all citizens were obliged to pay special 'berries' tribute' which included collection of certain berries and herbs. At the end of the eighteenth century, the Russian state stopped importing remedies from abroad, as all of them were either produced or collected within the country (Zabilin 1992: 13).

Thus, 'professionalisation from above' of the early university-educated medical practitioners resulted in their acquiring of an incommensurably higher social standing than lay practitioners had. At the same time, even in the late nineteenth century medical practitioners did not attempt to separate between early scientific and empirically-based ancient folk knowledge and relied on the time-proved folk medicine alongside the new therapies and techniques, such as vaccination, quinine, and some surgical advances such as anaesthesia and aseptic (Mirsky 1996). There is evidence that both types of knowledge co-existed at the end of the nineteenth century, when Russian medical periodicals publicised cases of graduate physicians practising 'secret' medicine, for example, applying koumiss (mare's milk) and using hypnosis as medicines 'for all diseases' (Kotok 2001). However, as in Britain (Stacey 1988), the politicised separation of medicine into 'orthodox' and 'unorthodox' appeared in the Russian language in the mid-nineteenth century with the introduction of homoeopathy and the 'professionalisation from within' of medical practitioners, who aimed to extend their



decision-making powers, to achieve a levelling of social status among medical practitioners and to increase their income.

### **3. Professionalisation from within medicine: the mid-nineteenth century to the beginning of the twentieth century**

#### **3.1. Introduction of zemstvo medicine: growth of opportunities for advancement of the relative independence of medical practitioners**

The 1860s in Russia were marked by the abolition of serfdom and by the spread of a populist Narodnichestvo movement among the Russian aristocracy and intellectuals who aimed at expressing the interests of peasants and who fought against serfdom and stood against the development of capitalism in Russia (Big Soviet Encyclopaedia 1989: 83). The tsarist government prosecuted democratic and revolutionary youth who shared the ideas of Narodnichestvo. The tsar, however, could no longer remain aloof to the spread of the populist movement. And Alexander II (1818-1881), the Liberator, who had emancipated the serfs, introduced the zemstvo reforms (1864), including the development of a health care system for the masses.

Zemstvos, the local governmental councils which brought together landowners, appointed officials and even representatives of peasants to decide local administrative concerns were instituted all over the country (Schechter 1997: 30). The government entrusted serious responsibilities to the zemstvos, under whose jurisdiction fell approximately three-quarters of the country's population living in the rural areas. Zemstvos became responsible for the promotion of public education and public health; the maintenance of hospitals and prisons; the promotion of local trade and industry; and arrangements for conducting local elections (Ramer 1982: 297-8). Some of the above mentioned responsibilities were obligatory, such as the management of charitable institutions, whilst others – the promotion of public health among them – were 'voluntary'. This fact created a unique situation where the elected representatives were not under any legislative limitation. Neither were there general rules for maintaining medical affairs, other than keeping the hospitals and their staff that the zemstvos had inherited in operation. The zemstvos were absolutely free to assign, or not to assign, resources to medicine as well as to employ additional physicians or other medical staff.

Zemstvo medicine became the first historical instance of the regionalisation of medical care and the provision of care to the large masses of population (Kalyu 1965; Ramer 1982; Mirsky 1996). This reform implemented the first public medicine free-of-charge for most of the population. The costs were paid for through taxes. Zemstvo physicians were supposed to work in medical centres located in the districts. Normally, these medical institutions were staffed with a physician and a feldsher. The word 'feldsher', was introduced into Russian under Peter the Great, and was rooted in German 'feldscher' meaning 'field surgeon' (Fasmer 1996: 189). During the period under study, feldshers were understood mainly to be 'physician-assistants' with limited medical education, providing first aid.

Zemstvo medicine has been regarded as a progressive and liberal attempt at providing care to large masses of population (Barsukov 1965; Field 1995; Kamenev 2001). On the whole, comparatively large sums of money were spent on medicine during the zemstvo period. From 1870 to 1912 the expenditures on zemstvo medicine increased from 2.5 million roubles to 57.7 million roubles (Zabludovsky 1981: 16). The ratio of health financing was equal to the modern budget allocations on public health in the advanced Western countries (Kamenev 2001). The possibilities and real achievements of zemstvos, however, varied. First, there were the differences between the funding received by them. For example, when altogether the zemstvos received about 8.750.000 roubles, the Orlov zemstvo got 503.000 roubles whereas the Ufa zemstvo got only 55.000 roubles (Veselovsky 1973: 270). Second, as it was mentioned above, much depended on the members of the local committee, who assigned money to various needs. As a result some zemstvos were more successful in attracting physicians, others – less successful.

The zemstvo service was undoubtedly hard and often dangerous for physicians as they had day-to-day involvement in the treatment of severe infectious diseases and even epidemics. However, the reward was significant enough (Zhuk 1963: 24). Another effective incentive strategy undertaken by zemstvos to attract physicians to the rural areas was the provision of living quarters, free travel expenses and the establishment of pension funds for retired physicians (Zhuk 1963: 31). At the end of the nineteenth century, some zemstvo authorities tried to obtain the service of physicians for lower salaries. However, these attempts were rather unsuccessful, as physicians proved to be well organised and would not apply for these low-rewarded vacancies (Kotok 2001: 34).



During the whole zemstvo period, the salary of physicians was approximately some 1.200 roubles yearly and even up to 1.600-1.800 roubles after 1905, when some physicians, disappointed with hardships, left the zemstvo service. At the same time, feldshers usually received a salary of some 300-400 roubles (Kamenev 2001: 3).

It has been argued that the decentralisation of government control brought by the reforms of the 1860s opened way for the advancement of the relative independence of physicians and direction of their own profession (Schechter 1997). Until the 1860s, physicians were predominantly at the service of the Russian nobility and gentry and tended to be dependent on the wishes of their paying upper-class patients and on the tsarist state which employed them. The scope and power of zemstvo physicians increased in their particular labour market, as they did not have to depend on the limited employment in big cities. By the late nineteenth century, hundreds of doctors voluntarily went to remote areas of the vast empire to establish clinics and hospitals to cater for the poor. During the years 1865-1910, the number of zemstvo physicians grew rapidly, from 350 to 3.100 (Field 1957: 78).

### **3.2. Distinctive features of ‘professionalisation from within’ in Russia**

After the abolition of serfdom and the institutionalisation of zemstvos, Russia started to move rapidly towards a capitalist economy (Black 1975: 47). Although industrialisation and modernisation processes in the country began much later than in Europe, the professionalisation of medical practitioners in Russia and the UK took place at approximately the same time – in the mid-nineteenth century. By that time the social standing of Russian and British medical professions was quite different. In Russia ‘professionalisation from above’ (McClelland 1991) had occurred: the medical profession was ‘assigned’ to the state sector, it was given social guarantees and distinguished in terms of prestige, although it evidently lacked power and was not well rewarded. In Britain the first signs of ‘professionalisation from within’ were evident. The state did not give any privileges to the orthodox profession until the 1858 Medical Registration Act, however, the identity of predecessors of orthodox medicine had started to take shape in the early nineteenth century with the formation of the Provincial Medical and Surgical Association, that became the British Medical Association (Batrip 1990). This lobbied for a single medical register and declared the shortfalls of the so-called ‘quack’ practices of groups like homeopaths and hydropaths (Saks 1996).

Despite this very different background, in the mid-nineteenth century the British and Russian orthodox practitioners were discontented with the scope of their autonomy and the ensuing status and financial position (McDonald 1995; Mirsky 1996). These professional groups realised that their professional knowledge-base might give them the right to social closure and enhancement of the status, power, and income. However, there were major differences, as far as the issues of realisation of professionalising strategies were concerned. The professional project of British medical practitioners was unfolding in the open market and the medical profession engaged in competition with lay alternative practitioners (Saks 1995b), whereas Russian practitioners launched a professional project within the state sector and mainly competed against lower qualified feldshers and against homoeopathy, the only 'alternative' therapy introduced to Russia at the time (Kapustin 1889; Zhuk 1963; Kotok 2001).

The Russian medical profession started to struggle only against those who could rival its authority within the state sector. As has been argued, practice in the open market was not an attractive career opportunity. At the time doctors were mostly preoccupied with the search for state employment in big cities and in affluent zemstvos. In the conditions of Russia until the last quarter of the nineteenth century, state service was the only way for a physician to find a continuing position, a reliable and steadily growing salary and pension (Gritsak 2003). The level of social development of the country did not allow the vast majority of physicians to obtain an income from private practice. The charitable institutions, relatively independent from the state, were poorly developed.

The first steps towards 'professionalisation from within' could be defined as an attempt by professional groups to extend their social standing to 'translate one order of scarce resources – special knowledge and skills – into another – social and economic rewards' (Larson 1977: 66). There were evident trends towards acquiring a monopoly of expertise in the market and a monopoly of status in a system of stratification. Attempts to professionalise of Russian physicians were reflected in the conflicts of physicians with the zemstvo managers of their local districts; efforts to achieve social closure in the state sector against paramedics; condemnation of homoeopathy and the creation of professional associations. All these signs of professionalisation are presented in detail in the following section.



### **3.3. Attempts of medical practitioners to obtain a position of dominance in the health sector**

#### **3.3.1. Expert knowledge as a resource for gaining a higher social position: conflicts with zemstvo managers**

It has been argued that physicians sent to zemstvos often could not help coming into conflict with the managers of their local district. Frieden argues that: 'many of these conflicts arose because the physicians lacked well-defined rights and obligations, and because in the early years of the program they may have had unrealistic expectations' (Frieden 1981: 117). One of the most typical instances where physicians and legislative officers clashed was over the question of professional expertise (*Vrachebnaya gazeta*, 1902: 267):

'It has become usual that physicians at the zemstvos to establish some kind of a caste. They do not hide their indignation when somebody endeavours even a minimal intervention in their affairs. So, one physician called a deputy an 'ignoramus' at the Perm zemstvo meeting. The deputy had tried to offer his considered opinion on some medical issue. Another physician was rebuked for not taking into account a remark of another deputy for 'this remark belongs to a person without medical education'! Because of some disagreements in the hospital at Atkarsk [a little town in the Perm province] all the physicians left their places. Such examples are numerous'.

Thus, one of the powers held by doctors at the time was an ability to vote with their feet. Zemstvo physicians started to develop a sense of professional identity and felt that they might decide independently the medical problems which fell under the jurisdiction of zemstvo deputies and officials. Zhuk argues that the struggle of physicians with the heads of the zemstvo had developed from the beginning of zemstvo medicine and was related to official rights and duties of physicians. The struggle was about the necessity of hospitals for the common people, about the need for feldshers to work under the supervision of doctors, and about the system of circuit or stationary systems (Zhuk 1963: 356). From the beginning of zemstvo medicine, the elective deputies at zemstvo meetings adopted the circuit system which meant that physicians were supposed to make visits to the feldsher stations where patients were waiting. Only by the 1890s, almost everywhere, either the stationary or mixed (stationary-circuit) system of

providing medical support was adopted which suited doctors. These discussions often developed into conflicts that resulted in physicians' leaving zemstvo service for employment in other zemstvos.

### **3.3.2. Competition with paramedics: attempts at social closure**

What threatened professionalising Russian doctors was the preference that quite a few zemstvos gave to feldshers. The crucial advantage of feldshers over doctors in the eyes of some zemstvo officials was lack of steep demands and lack of arrogance (Zhuk 1963: 360). The existence of feldshers meant that physicians could always be replaced by the less specialised medical personal. Many deputies of the zemstvo often preferred to keep three or four feldshers instead of one physician. There was a saying: 'a physician is a doctor for the rich; a feldsher is a doctor for the poor' (Kotok 2001: 126). Physicians took the preference given to feldshers as an obstacle, which hindered their attempts to increase their influence and dictate their will within zemstvos. The independent feldsher became an embodied denial of the exclusive competence of physicians. Feldshers who acquired popular success, even on the basis of their proven skills as practitioners, inevitably tended to postpone the day when licensed physicians could claim successfully popular confidence (Ramer 1982: 297-298).

Physicians well realised the challenge that came from feldshers who also struggled for a stable position in the health care division of labour. Ramer argues that no issue in zemstvo medicine brought more bitter discussions within the zemstvos than that of so-called 'feldsherism', although feldshers in Russia had very different medical education backgrounds (Ramer 1976: 213-225). There were those who had been chosen in their younger years to be taught by the landlords' wives. There were those who had been taught by apprenticeship during their service in army or navy. There were also graduates of feldsher schools who had about four years of training. Nevertheless, a large majority of zemstvo physicians saw all feldshers as poorly educated persons who should only be allowed to practise under the supervision of physicians. Some zemstvo physicians called 'feldsherism' an 'affront to zemstvo medicine' (Kapustin 1889: 25). However, negative opinion towards them was prevalent, for example, as it is seen in the book by Osipov and colleagues (Osipov *et al.* 1899: 67):

'Feldsherism means placing independent medical activity at the disposal of the lower medical staff which has neither appropriate training nor even elementary



basic education. Such an approach can solve the problem of the organisation of zemstvo medicine just superficially, by the introduction of a lot of cheap 'doctors'. Yet this undermines those scientific and cultural grounds of zemstvo medicine, which are of great importance for the rational provision of health care'.

Physicians were anxious about their own position of dominance. Quite illustrative is the reaction of the members of the Fifth Meeting of the Russian Physicians to the speech of Dr. Herzenstein in 1902. He compared the number of physicians in Russia and England and stressed that there were much more physicians in England in terms to the population to be covered than in Russia. He concluded that Russian physicians could do nothing without the help of feldshers. Dr. Herzenstein proposed that, on the one hand, where feldshers already provided treatment on their own, the situation should be legitimised. On the other hand, the training of feldshers ought to be improved. The participants of the meeting firmly rejected the proposals, for they feared that the zemstvos would employ such 'improved' feldshers instead of physicians (*Vrachebnaya gazeta* 1902: 150-151).

Russian doctors were rather successful in their social closure techniques against feldshers, as throughout much of the zemstvo period feldshers in independent practice were confined to less prestigious army or navy service (Ramer 1982: 292). They remained in the position of subordination to medical practitioners and seldom aspired for independent practice (Veselovsky 1973: 270).

### **3.3.3. Formation of professional associations of medical practitioners**

It has been argued that the whole tradition and organisation of zemstvo medicine was one of the struggle of medical practitioners for autonomy against autocracy (Hyde 1974: 37). Zemstvo physicians understood that disparate practitioners could not achieve full autonomy and therefore started to develop professional organisations and associations (Frieden 1981). In 1881, the Pirogov Society, named after an outstanding Russian doctor Nicholas I., Pirogov (1810-1881), was organised on a national scale with local branches throughout the Russian territory (Sigerist 1947: 18, 76). The society became the mouthpiece of the Russian medical profession. No Russian medical society could be compared with the Pirogov Society neither by the number of its members, nor by the

notable doctors present at meetings, nor by its influence. One of the main functions of the Pirogovists, as these physicians were called, was to campaign for medical, social and political reforms. At regular intervals, the Pirogovists held congresses at which their work was reviewed, papers read and discussed, and reforms proposed (Sigerist 1947: 18, 76). Pirogov himself planned 'to create a corporate consciousness among doctors, maintain the doctors' control in the workplace, make sure doctors played an active role in bettering societal ills, and expand the independence and prestige of Russian doctors to be on par with their colleagues in the West' (Schechter 1997: 31).

Members of the Pirogov Society, as opposed to some radical political groups which took a terrorist anti-government stance, tried to maintain their power alongside with the government (Frieden 1981). However, most social demands of physicians usually remained unanswered by the government. This cold attitude toward the proposals of physicians can be partly explained by the negative attitude of the monarchy towards the desire of physicians to change the legislative position of the medical profession in general. The physicians believed that in contrast to the existing health policy, matters of health ought to be the exclusive prerogative of physicians, to whose expert judgement, lay people, including civil servants in the medical administration, ought to defer. For their part, officials of the enormously powerful Ministry of Interior refused to defer to 'expert medical opinion' even within the ministry and blocked any attempt to establish a separate Ministry of Health beyond the control of medical bureaucracy (Solomon and Hutchinson 1990: 8). In this context, even the most conservative reformers found their proposals blocked.

Nevertheless, the physicians started to constitute a serious social and political force and a distinct opposition to the regime. The Pirogov Society, during the years 1883-1917, together with the weekly magazine *Vrach* ('Doctor'), became the most influential medical institutions, which completed the process of consolidation of the Russian medical profession (Frieden 1981). Those early years of the twentieth century were marked by a large movement of unionisation among health workers. Physicians also began to organise unions to defend their interests and present their views (Field 1957: 48). It is of interest to draw a comparison with Great Britain, where in the early part of the twentieth century, the question of unionisation for the medical profession became an issue that was debated and turned down by the British Medical Association on the grounds that 'in law a trade union is an association of workmen or masters and that



doctors can hardly be considered as workmen and certainly not masters' (Carr-Saunders and Wilson 1933: 91). Unlike Britain, all over Russia, there had been the rapid growth of medical unions based primarily on the physicians' specialties and places of employment: hospital, city, army, navy, transportation, and factory. Some of these unions and associations combined into the All-Russian Union of Professional Associations of Physicians. Field argues that this union represented 'the unionised medical profession attempting to define its place, role, and status vis-à-vis other occupational groups in the new democratic and liberal society that was to emerge from the February Revolution' (Field 1957: 28).

#### **3.3.4. The origin of medical 'unorthodoxy': the struggle of orthodox medical practitioners against homoeopathy**

As has been argued, there was no rivalry between university-trained medical practitioners and lay practitioners of traditional medicine, the clientele of the latter was limited and usually comprised of the poorer rural inhabitants. Lay practitioners were not allowed to practise within the official state health sector. At the same time, traditional Russian medicine was not discredited and had been largely integrated into the practice of orthodox medical practitioners. Many doctors widely enriched their practice by hirudotherapy, apiotherapy, hydropathy, and above all herbalism. Homoeopathy became the only therapy which was officially condemned by Russian doctors, as only this method was undertaken by medically qualified practitioners and represented a threat to the hegemony of the medical practitioners of the day.

Homoeopathy entered Russia in 1821, and had attracted the interest of higher circles in St. Petersburg (Karpeev and Kiseleva 2002: 79). Although the first reaction of the Russian professional medical press toward homoeopathy was rather benevolent, the orthodox profession soon became convinced that homoeopathy might represent a real threat to its foundation. Since 1829, when Dr. Herrmann had been entrusted by the tsar with testing homoeopathy in a military hospital, Russian allopaths demonstrated clear intolerance and even keen hostility toward their homeopathic counterparts (Kotok 2001). In 1833, the Medical Council, the 'Ministry of Health' of the time, had to consider the legal issue of the homoeopathy practice (Karpeev and Kiseleva 2002: 79). The overall opinion of the Russian medical administration was rather negative as seen in the report 'Conclusions of the Medical Council Regarding Homeopathic Treatment'

issued in December 15, 1831 (Medical Council 1832). The Council vigorously attacked the new method and its adherents:

‘This new speculation [homoeopathy] had no influence upon medical practice and became a subject of strong and true criticism, which was deserved by its groundless accusations of allopathy and by its absurd, exaggerated and one-sided speculations... Yet as any novelty strongly influences minds, especially those inexperienced, there is no surprise that homoeopathy according to the innate inclination of the human being to believe in unusual and mysterious led many people astray’ (Medical Council 1832: 50).

However, homoeopathy had quite influential patrons both among its clients and as well as some qualified orthodox doctors. Therefore the Medical Council permitted its limited appliance in September 1833. The rules under which the method could be practised were stated at the time as the following (The Whole Collection of the Laws of the Russian Empire 1834, quoted in Kotok 2001): 1) only licensed physicians may apply homoeopathic treatment; 2) homoeopathic doctors are allowed to prescribe homoeopathic medicines to be obtained from allopathic pharmacies if these medicines are prepared there; 3) homoeopathic doctors are allowed to offer homoeopathic medicines from their own kits in emergency in two closed envelopes: one – for the patient, the other – for future investigation in case of the patient’s death; 4) the price for homoeopathic medicines shall be defined according to the Apothecary Rates; 5) reports on the action of homoeopathic treatment should be presented monthly to the local health care departments and the Medical Boards in the districts.

Thus, the attitude of medical officials towards homoeopathy was extremely negative, and orthodox practitioners followed the same pattern. They were sceptical about the technique and wanted to protect their market. Since around 1890, the struggle of the Russian professionalising orthodox medical profession with homoeopathy became irreconcilable (Frieden 1981: 127-128). Homoeopathic doctors were expelled from allopathic societies. Some professors delivered lectures in which homoeopathy was condemned. Later on, these lectures were published as brochures and pamphlets. This fact reflected a growing fear of the Russian conventional physicians of homoeopathy and its increasing influence, especially in the light of the decision of Nizhnedevitsk zemstvo to invite a homeopath to treat zemstvo patients instead of an allopath (Kotok



2001). Those allopathic physicians who ventured to consult with homeopaths were attacked in the allopathic press.

Although the Russian orthodox profession had no such institutions like the Royal College of Physicians, which could establish a certain legal policy toward 'irregulars', the Pirogov Society of Russian Physicians and the weekly journal *Vrach* were very influential and could control professional issues. The ninth meeting of the Pirogov Society in 1905 doomed homoeopathy and its practitioners. A resolution was passed and reported in the Proceedings of the ninth Meeting of the Pirogov Society in 1905, saying (Bulatov 1905: 276):

'...while recognising homoeopathy as a kind of wizardry, the section [of Public Health] considers any participation of physicians in this affair as being incompatible both with scientific knowledge and with the ethical principles of a physician. As to the struggle against this social evil, the important thing is wide publicity and popularisation of the information on medicine and natural sciences'.

Homoeopaths were not organised enough to oppose the united professionalising orthodox profession. There were altogether some 20-25 homoeopathic societies in Russia, which mostly were established during the 1890s, the most fruitful period for Russian homoeopathy. There were many disagreements between the pre-revolutionary homoeopaths, as there were two pronounced streams: lay practitioners who preferred not to support doctors and their 'scientific' interests and former orthodox practitioners (Karpeev and Kiseleva 2002).

### **3.4. State acknowledgment of the professionalisation of medical profession**

The February 1917 Revolution overthrew the tsardom (Romanov dynasty) and established the Provisional Government, which lasted for six months until the Bolshevik Revolution. The medical profession, as a corporate body, was given the right to reform the medical system along the lines established in the fifty years preceding the Revolution. Indeed, the Provisional government gave the profession an opportunity to pass from talk to action. As has been argued, in the past all recommendations and proposals of the Pirogovists had been either ignored or rejected by the Tsar.

Given the choice, the medical profession introduced the principal of partnership between the profession and the state. During this period the Central Medical Sanitary Council was formed, which became an official body concerned with the organisation of medical services working closely with government (Field 1957). Needless to say, the Pirogovists played a critical role in the formation of the Council. They wanted an autonomous national health service run by the medical profession with payment for the services provided from local insurance funds or from private sources (Navarro 1977: 19). The government provided necessary financial backing for the implementation of a health service organised on this principle.

The end of the nineteenth century and the beginning of the twentieth were characterised by the trend towards professionalisation and the February Revolution strengthened the power of the medical profession that had accumulated a strong directing and advisory power. Physicians had claimed exclusive rights to a particular knowledge base through the conflicts with zemstvos and the government and gained the freedom to determine the organisation of medical services in the country. They had tried to implement social closure practices to distinguish themselves from feldshers and as a result of the February Revolution gained control over entry into the profession, which had been shared with the state. The professionals got the exclusive right to supervise the content of examinations; the terms, conditions and goals of education and training; and the numbers of 'recruits' (Frieden 1981). Above all, the physicians had formed various professional organisations and associations which became interest groups based on the shared values and a professional ideology. Although the physicians at the time had not achieved full autonomy, nor had they gained a very high status as professionals, still the initial trends of professional power, a corporate identity and professionalism were all clearly evident at the beginning of the twentieth century by the October Revolution of 1917 (Frieden 1981).

## **4. The 'deprofessionalisation' of rank-and-file doctors and the triumph of biomedicine**

### **4.1. The Soviet power struggle against the medical profession as a corporate body**



In 1917, the majority of doctors tended to hold liberal rather than proletarian views. They realised that they were regarded by the latter as 'class enemies' (Barsukov 1965: 51). The professionals felt that should Bolshevik policies be implemented, they would lose their dominant position over decision-making in the health sector. In line with the egalitarian notions, physicians and their various social groupings were bound to see their status reduced to that of 'workers'. That would mean that the physician would be considered the 'equal' of the paramedics and other hospital workers. As such, their authority over other medical personnel would decrease. Consequently, the majority of the Pirogov Society joined the parties that campaigned against the implementation of the Bolshevik program (Field 1957; Hyde 1974). There is historical evidence of the call of professionals to sabotage the Bolshevik government. In November 1917, the Board of the Pirogov Society adopted the resolution which appealed to doctors to sabotage any measures taken by Soviet power to provide health services (Obshchestveny Vrach 1917: 79). As a result of this resolution, the Pirogov Society split and the supporters of the Bolsheviks left the Society and strongly dissociated themselves from their leaders (Hyde 1974: 32).

The unwillingness of the new regime to tolerate the profession as a powerful corporate body resulted in the official dissolution of the Central Medical Council in 1918, which was replaced by the Central People's Commissariat of Health (Barsukov 1951). Health institutions were put under the control of the local Soviets comprised of peasants and workers – local authorities elected by all wage earners. Representatives of the health workers were a very small minority among them. Each institution would have a director appointed by the local Soviet, with an advisory body elected by workers of that institution. Thus, executive power remained with the Soviets, while medical workers enjoyed only an advisory role.

It is interesting to note that the Bolshevik government never forbade private practice. However, the existing economic conditions brought about a rapid dissolution of the clientele for private practice. Thus, the majority of physicians were bound to be employed by local Soviets and to be paid a basic salary. Local Soviets were quite powerful in the early 1920s, as the Bolsheviks were apprehensive of the fact that total centralisation of power in the social sphere could have meant an increase of power of the former state apparatus. Later on, the Central People's Commissariat of Health became all-powerful and the local Soviets became bodies that simply carried out its

instructions. By the end of the 1930s, health care had reached the centralised form it would continue to have during the Soviet period (Field 1957).

The All-Russian Union of Professional Associations of Physicians was another potential focus of resistance to the Soviet regime. The Bolsheviks were unable to capture the leadership of the Professional Association of Physicians. They were, however, more successful in obtaining control of the unions of semi-professionals, on which the Bolsheviks relied to counter the power of the medical association (Barsukov 1951: 123). Feldshers, sympathetic to Soviet power, formed the All-Russian Union of Medical Workers in the spring of 1919. They were encouraged to assume leadership in medical affairs. Physicians, pharmacists and veterinarians, however, did not join the union. In the beginning of 1920, the pharmacists and veterinarians withdrew their objections and joined the union. The physicians remained outside. The Soviet government was left with the only way out: the All-Russian Union of Professional Associations of Physicians was declared illegal and dissolved in 1920. The same year physicians were allowed to join the All-Russian Union of Medical Workers only in nonpartisan sections. By 1924, the nonpartisanship clause was eliminated (Haines 1948: 32). In the early years of Soviet power, many physicians were allowed 'not to join' the union, and those who were exclusively in private practice were ineligible to join (Haines 1948: 33). Later on, union membership became practically a prerequisite for state employment.

By February 1925, the Pirogov Society was forced to disband, dissolving the one last remnant of the political autonomy of the pre-revolutionary physicians (Schechter 1997: 33). The final dissolution of the Pirogov Society and the integration of the physicians' union into the overall health workers' union served to erode the professional identity of physicians as an elite group. Again, comparing events in the Great Britain in the establishment of the National Health Service following the 1946 Act, there was a contrast in relations between the state and the physicians between Lenin's Bolshevik Party in the creation of the socialist health care in the Soviet Union and Bevan's Labour Party in Great Britain. As Navarro (1977: 21) has argued Bevan in the lead up to the 1946 Act questioned neither the professionalism and class interests of the profession nor the class structure in Great Britain. Lenin's strategy, to the contrary, did question these and transformed the professional and class interests of the medical profession. For Lenin, the strategy towards the medical profession was a political one of



deprofessionalisation and democratisation of the health sector, so that physicians were subsumed into the class of workers.

#### **4.2. Distinguishing features of Soviet medical practitioners**

In 1917, the new political elite implemented the politics of the mass production of professionals. On the one hand, the country suffered from severe epidemics and there was a demand for qualified medical assistance. On the other hand, the policy of mass production of intellectuals was adopted to subordinate the intellectual elite (Volkov 1999). The increased production of professionals was aimed at 'wiping out' professional group identities and the substitution of oppositional professionals with loyal ones. At the Soviet time, the Soviet Union produced more professionals such as doctors, engineers and scientific workers than any other industrial country, although the level of professional remuneration was lower than that in such countries. At the end of 1980s, the social layer of professionals or specialists, as they were termed, included 37 million specialists, of which 16 million had higher educational qualifications (Volkov 1999). Since 1926, the number of professionals has increased more than ten-fold. Before the Revolution, only 3 million people were engaged in the sphere of intellectual work (Volkov 1999).

As far as the production of doctors is concerned, there has been a much higher ratio of Soviet physicians to population than elsewhere. The speed of production of physicians increased dramatically after the October Revolution from 22.000 in 1917 to 63.162 in 1928 (Hyde 1974). On average, during the Soviet period, the number of doctors was 45 per 10.000, which was twice the number compared to health systems in the United Kingdom and the United States (Field 1957). Physicians also tended to be used for a wider range of tasks, many of which would be carried out by less qualified health care workers in other countries. They typically had a relatively low status, earning about 70% of the average income nationally – very different from much of the rest of the developed world (Davies 1989; Allsop *et al.* 1999).

The Soviet Government monopolised control over the entry of professional groups and aimed to achieve a rapid growth of doctors. The rapid, and to some extent artificial, growth of physicians, had an irretrievable impact on their social standing. Higher education and knowledge-based professions have been discredited by the fact that in

their number were included some manual occupations. The political elite had managed to abolish professions as corporate entities. The elite social standing of professionals, the development of a specific professional culture and ethics were destroyed. Moreover, traditional professionals, such as doctors and lawyers lost their main differentiating advantage: the possession of a specialised symbolic knowledge. More than 37 million formally possessed higher educational qualifications and cultural capital, but many lacked the broader cultural background and aspirations associated with 'an intelligentsia' (Read 1990).

Aside from state control, there have been other features of the Soviet physicians that have set them apart (see, amongst others, Pipes 1961). One factor is the 'feminisation' of medical profession. This became one of the most particular features of the Soviet medical profession and was connected in part with state politics – insofar as there was a drive towards equal rights for all (Harden 2001). A much higher proportion of professionals has been female than in other advanced industrial countries. In 1917, 17% of doctors were women, yet by 1940 61% were women. From the 1950s the figure fluctuated around 65-70% (Ryan 1989: 38), whereas, for example, in Britain, only 29% of doctors are women (Crompton and Harris 1998). Another priority for the former Soviet Union was national politics. The 'nationalisation' of the intelligentsia drew non-Russians within the Union into intellectual work. The very low entry prerequisites for some nationalities among the non-Russian population had political advantages. It provided the possibility for the rapid growth of medical workers from other Russian Soviet Republics.

The increased numbers of intellectuals led to a relative depreciation of their competence and knowledge. In the same way that different titles and honorific rewards lose their value when the number possessing them grows, there has been an inverse relationship between the social standing of the intelligentsia in terms of prestige and income, and its size. Intellectual labour depreciated in value immediately after the October Revolution. Already in the 1920s, the average income of a 'rank-and-file' physician had become either equal to, or lower than, a worker's salary. In the 1980s, the quality of life of intellectual workers was lower than that of manual workers. The salaries of the majority of teachers, doctors and scientific workers were 3 to 4 times lower than that of manual workers. The pre-revolutionary social hierarchy was therefore turned upside-down. It



has been argued that over the period, the relative socio-economic situation of the intellectual layer worsened by a factor of 10 (Volkov 1999).

#### **4.3. Status inconsistency of the social position of Soviet doctors: the applicability of the 'deprofessionalisation' thesis**

It can be suggested that Soviet doctors were characterised by the inconsistency of social standing, understood as the degree of relationship (coordination) between the dimensions of social standing such as 'cultural', 'economic' and 'political' (Lenski 1961; 1966). For example, Anglo-American medical professionals have had a consistently high social standing throughout the twentieth century (Freidson 1994; 2001), while Soviet doctors had an inconsistent social standing: a high position in terms of cultural resources and a lower position in the power and economic hierarchy.

As has been highlighted, Soviet doctors lost their power in economic and political dimensions. They no longer exercised the right to determine their remuneration and to make independent policy decisions as the legitimate experts on health matters (Elston 1991: 61). As regards to their 'clinical' or 'technical autonomy', physicians lost control over the criteria for entrance into the profession when government quotas for medical school places were introduced. And their ability to change the curriculum of higher medical institutions was also constrained by the limits of state finance. However, the doctors still exercised some control over the organisation of medicine and terms of work (Davis 1989: 287). The profession reserved the right to set its own standards and control clinical performance, exercised, for example, through clinical freedom at the bedside, professional control over training and collegial control over discipline and malpractice (Freidson 1994). The state determined the level of overall resources devoted to socialised medical care, leaving the profession largely free to determine the use of these resources, under the rubric of clinical autonomy (Klein 1983: 57).

As Elston argues, 'salaried status and state intervention are not incompatible with a high level of some aspects of professional autonomy and dominance' (Elston 1991: 66). It is an empirical question how far a change in one type of control has implications for power over other aspects or at other levels. It can be suggested that Soviet doctors maintained medical authority over health users and paramedics through the giving of commands. Thus, Soviet doctors were accorded prestige as intellectuals (Mansurov and

Semenova 2001). Intellectual professions were still considered as forming cultural elite. Most school graduates aspired to become doctors, scientific workers, physicists or engineers. Intellectual occupations enjoyed greater prestige than did manual ones in the Soviet society, as it was in the West (Hayward and Labedz 1963).

Thus, a decline in some types of medical power did not necessarily result in the 'deprofessionalisation' of Soviet medical profession. It would not be justified to apply to the Soviet reality the model of 'deprofessionalisation' suggested by Illich which referred to a radical democratisation of knowledge and skills leading towards the elimination of a separate skilled cadre of healers (Illich 1976). Johnson's model which referred to a diminution in collegiate control over medical work in favour of greater mediation by third parties (Johnson 1972) is only partly applicable to Soviet physicians. The applicability of Haug's model of deprofessionalisation is also contentious, as she stressed changes in the relationships between doctors and their patients which led to a decline in the cultural authority of medicine and in the extent of its monopoly over health-related knowledge (Haug 1975). However, no direct evidence was presented by Haug on the trends of demystification and routinisation of medical procedures in industrialised countries, rendering them more amenable to lay scrutiny (Elston 1991: 64).

The elimination of the privileged position of physicians within the health division of labour occurred with the implementation of the Soviet power. However, the diminishing medical power cannot be regarded as 'deprofessionalisation', as Soviet physicians preserved high prestige, and therefore acquired some cultural and clinical autonomy. The decline in medical power did not affect the social standing of medical profession relative to lay practitioners, as the social standing of the latter was in marked decline (Barsukov 1965).

#### **4.4. The triumph of biomedicine and the withdrawal of traditional medicine**

As far as traditional medicine in Soviet Russia was concerned, this was neither prohibited nor encouraged (Fulder 1996: 107). It simply lost its pre-revolutionary significance as the twentieth century unfolded, as it did not fit into the modernised socialised medicine based on biomedical principles. As distinct from Britain, where



unorthodox therapies became marginalised with the development of the medical profession through the 1858 Medical Registration Act that established exclusionary social closure and the promotion of orthodox medicine (Waddington 1984), unorthodox therapies in Russia had been largely integrated into the practice of orthodox medical practitioners until they were disregarded by the Soviet state (Mirsky 1996). Since then, doctors have been subordinated to the perceived interests of the socialist state aimed at modernisation and urbanisation of the country.

The cardinal principles of the Soviet health care system were defined as follows: (1) medicine should serve the masses; and (2) prevention should come first (Field 1957). In practice, in the first quarter of the twentieth century the move was towards 'hospital medicine' in the Soviet Union. Similar trends occurred in Western countries earlier (Saks 1997a). This new phase meant the change from treatment of individuality towards effective and quick treatment for the masses and the change from the earlier focus on the individual as a whole person towards generic classification of diseases and standardised treatment. This included, at a latter stage, the development of 'laboratory medicine', which removed diagnosis even further from the whole patient, who became depersonalised and conceived as a 'complex of cells' (Jewson 1976).

These Soviet state reforms resulted in the withdrawal of traditional medical therapies. Apiotherapy and hirudotherapy were too intricate and expensive for the treatment of the masses. Herbalism was also time-consuming, required an individual approach and was not standardised enough. This was to say nothing about Indo-Tibetan medicine, which required over twenty years of medical qualification. Traditional medicine receded into the background with the rapid growth of the numbers of Soviet-trained physicians: there were three times as many medical doctors in 1928 as in 1917. Their medical curriculum in higher and secondary medical institutions was formed according to the demands of the new Soviet socialised medicine. As distinct from pre-revolutionary physicians, their knowledge of traditional medicine was rather superficial.

The Bolshevik government never forbade private practice of orthodox or traditional medical practitioners. However, according to the 1924 Decree, only people with secondary and higher medical education were admitted to work within the state sector. Thus, lay traditional practitioners lacked state sanction – they could not practise in state medical institutions and were mostly confined to the low prestige rural private fee-for-

service sector. Despite sophisticated centres of excellence in major cities, Soviet official medicine in rural areas was starved of resources, and part-time lay practitioners supplied rural inhabitants with first-aid medical assistance (Davis 1989). Homoeopathy became the only alternative therapy officially banned by the Soviet state, as it did not fit into the Soviet worldview. Homoeopaths had always managed to thrive on an upper-class clientele of nobility and royalty (Nicholls 1988), and Russian homoeopaths built up clientele even when orthodox doctors lost the opportunities for private practice during the early years of the Soviet power (Kotok 2001). The Soviet state, however, could not tolerate the social connections of homoeopaths with the wealthy clients who were proclaimed ‘socially alien elements’ and as a result the homoeopathic societies were dispersed and in 1938, homoeopathic practice was forbidden (Kotok 2001).

The overall attitude of the Soviet state towards the indigenous folk therapies was benevolent. The Soviet government saw the development of science in the country as one of the major priorities (Ruzavin 1978). Traditional folk medicine was seen as an interesting and important object of investigation, though the interest towards it seldom went beyond the research. The state was mostly concerned with the ancient therapies: herbalism, and Indo-Tibetan medicine. The systematic studies of traditional medical systems began in the 1930s (Kiseleva *et al.* 2000: 29). Moreover, few unorthodox therapies were concentrated in the hands of Soviet orthodox practitioners who researched and unofficially used them. Some unorthodox medicine existed latently within the official health care, whereas others were used within the self-help sector during the Soviet period. This covert existence of unorthodox therapies in the Soviet period had a salutary impact on the post-Soviet development of alternative medicine, described in chapters VII and VIII.

The main periods of development of medicine in Russia are shown in a graphical form in Table 3.1 below:



**Table 3.1: The historical evolution of medicine in Russia**

	Societal changes	Popular therapies	State of medicine
9 <sup>th</sup> – 10 <sup>th</sup> century AD	Formation of the Russian state.	Herbalism, diet, magic rituals.	The birth of traditional medicine
10 <sup>th</sup> – 17 <sup>th</sup> century	Introduction of Christianity.	<ul style="list-style-type: none"><li>▪ Herbalism;</li><li>▪ Apiotherapy;</li><li>▪ Hirudotherapy;</li><li>▪ Hydrotherapy;</li><li>▪ Bone-setting;</li><li>▪ Christian healing;</li><li>▪ Indo-Tibet medicine (in two regions Kalmykia and Buryatia).</li><li>▪ Magic rituals (charms, amulets) popular with the folk, forbidden by the Church.</li></ul>	The golden age of traditional medicine
18 <sup>th</sup> – mid 19 <sup>th</sup> century	Age of Enlightenment.	Introduction of systematised quasi-scientific medicine (quinine, heroic therapies)  The same traditional therapies are practised.	Development of 'professional' sector of medicine of university-trained doctors. Traditional medicine retains its social position, though lay folk practitioners lose their prestige.
Mid-19 <sup>th</sup> – 1917	Introduction of capitalism.  Professionalisation of conventional doctors.	Introduction of aseptic, antiseptic and anaesthesia.  The same traditional therapies are practised.  German doctors introduce homoeopathy.	Wide biomedicine dissemination intertwined with traditional medicine.  Orthodox doctors struggle against homoeopathy.
1917-1992	Coming of the Soviet socialised state.  Modernisation and urbanisation of the country	Large use of drugs and surgery 1938 homoeopathy forbidden. 1960 acupuncture introduced for research purposes. 1983 osteopathy introduced	Triumph of biomedicine.  Traditional folk methods are ousted into self-help sector and folk sector of lay practitioners

## Conclusion

This chapter has provided a balanced account of the development of orthodox and alternative medicine in Russia during various historical periods. It has been demonstrated that 'professional' medicine, professional in a sense that it was rendered by doctors (mainly foreign) with university diplomas, was introduced in Russia as early as the seventeenth century. These foreign 'professionals' did not discriminate against Russian traditional medicine. It had been integrated into the practice of university-trained doctors, until it was disregarded by the Soviet state. It has been argued that there was no rivalry between university-trained medical practitioners and lay practitioners of traditional medicine although the clientele of the latter was limited and usually comprised of the poorer rural inhabitants. Throughout the period of Russian history analysed, homoeopathy became the only alternative therapy which was officially condemned by Russian doctors, as only this method was undertaken by medically qualified practitioners and represented a threat to the hegemony of the medical practitioners of the day. In the Soviet period, socialised medicine brought about the predominance of orthodox biomedicine, while all alternative therapies were marginalised into the folk and self-help sectors. This situation changed with the economic and political reforms of the 1980s-1990s, which affected the social and professional standing of both orthodox and alternative medical practitioners. This chapter and the preceding ones have articulated the theoretical and historical perspectives of the thesis. They have been based on literature reviews and provide the background for the contemporary data collection presented in subsequent chapters.



## IV. METHODOLOGY AND METHODS

The primary aim of the research on which this thesis is based is to assess the professionalisation process of orthodox and alternative doctors in Russia, drawing on a theoretical framework developed from the Anglo-American sociology of professions. This objective informed the methodology. This chapter provides the link between research questions posed in previous chapters based on literature reviews and the methods of contemporary data collection and analysis. The thesis consisted of two stages of contemporary data collection, as it had two subjects of investigation: orthodox doctors and alternative practitioners. The first stage of the research for the thesis considered orthodox practitioners and whether social and political changes had increased the potential for greater professionalisation. It was based on the INTAS-funded research project *Russian Doctors: Social Attitudes and Strategies for Adaptation*, in which this author participated in all the stages: from the research design, the composition and piloting of the questionnaire to the data analysis. During the INTAS-project, the author also carried out independent field work in Komi region. It included the questionnaire survey of 149 respondents and twenty interviews with heads of medical institutions and heads of departments which were conducted prior to, and after, the quantitative research with the purpose of piloting the questionnaire and interpreting the results. The second stage of the research was oriented towards the study of alternative practitioners and was based on interviews with nineteen alternative practitioners from the major Russian professional associations of alternative practitioners. These two stages of the research are described more fully below.

The chapter is in five parts. In the first part of the chapter, the origins of both stages of the research are discussed in order to place them in context. In the second part of the chapter, theoretical considerations for the multi-method methodology approach are reviewed. The third part of the chapter presents the first stage of the research based on the INTAS-project. It provides information about data collection and analysis: the research design; the sample and its representativeness; the instrumentation of the research; the operationalisation of basic theoretical concepts used in the research; and the management and analysis of data. The fourth part of the chapter describes the process of data collection and analysis during the second stage of the research. It provides full information about all phases of this interview survey. The third and the

fourth parts provide the central focus of the chapter and outline the multi-method approach adopted and the influence of analytical and enumerative induction on the design and analysis of the data. Limitations of the research are considered in the fifth part. The chapter closes with a conclusion which draws together dominant themes. The difficulties encountered during the research are discussed where relevant through the chapter.

## 1. The origins of the project

Before the INTAS-project, this author participated in several research projects related to the social standing of Russian doctors, such as, for example, a study on the rise of private medicine *Ways to Private Medicine in Modern Russia*<sup>10</sup> and a study of doctors from Komi region *The Dynamics of the Social Status of Provincial Doctors*<sup>11</sup>. These research projects were descriptive. They were undertaken within the frameworks of a social-psychological perspective, dominant in the Russian social research in professions (Mansurov *et al.* 2004). Research was focused on social attitudes, values and work motivation of medical practitioners. As was discussed in the Introduction, two important dimensions of the social standing of professionals – their economic position and their position within the power structure – have been largely ignored by Russian sociologists. Professor Mansurov<sup>12</sup> and this author became interested in extending the understanding of the nature of the classic Anglo-American theories of professions, where professionals have primarily been studied as corporate actors, who have acquired privileges and a more or less independent social position.

The desire to make up for the lack of research on the changes in the social standing of Russian physicians – their labour and life conditions, economic and power position – resulted in the joint INTAS-funded research project *Russian Doctors: Social Attitudes and Strategies for Adaptation* conducted by the Institute of Sociology of the Russian Academy of Sciences in Moscow and the Faculty of Health and Community Studies at De Montfort University in Leicester, in consultation with the Institute of Occupational

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<sup>10</sup> Luksha, O. (1999) 'At the crossroads or where the way to private medicine leads', in Mansurov, V. (ed.) *Russian Sociology Today*, M.: Russian Society of Sociologists.

<sup>11</sup> Luksha, O. and Mansurov, V. (1999) *The Dynamics of the Social Status of Provincial Doctors*. Paper for the IV European Conference of Sociology, Amsterdam.

<sup>12</sup> The head of the Department of Studies of Problems of the Intelligentsia of the Institute of Sociology of the Russian Academy of Sciences who was one of the supervisors of the thesis.



Health in Helsinki. It was argued in the previous chapters that this area was ripe for development as there had been no studies of Russian professionals based on the Anglo-American theoretical and methodological concepts. The INTAS-study provided an excellent opportunity to use some of the Russian conceptual paradigms and to explore the dominant Western theories of professions and professionalisation. As a consequence of the expertise of Professor Saks in alternative medicine, a participant in the INTAS-research, who subsequently became one of the supervisors at De Montfort University, my interest in the professionalisation process of alternative practitioners in Russia grew. Drawing on his studies of orthodox and alternative medicine and the insights of other key Western authors writing on the subject, this author attempted to explore an uncharted territory of alternative medicine in Russia. Some of the questions on alternative medicine were incorporated into the INTAS questionnaire. However, the information had to be informed by qualitative data to become broader and more well-rounded (Geertz 1973). From January to March 2003, nineteen interviews with the heads and rank-and-file members of major Moscow and All-Russia alternative professional associations were conducted.

The purpose of the research was to describe the professionalisation process of orthodox and alternative doctors in Russia using a multi-method approach. To put qualitative and quantitative data in the appropriate historical and theoretical context, the author carried out a historical investigation on development of orthodox biomedical profession and its counterpart – alternative practitioners. The historical research was mainly based on archival documents, statistics and old newspapers and journals. It helped to develop an understanding of some peculiarities of the modern professionalisation phenomena. As Drake comments:

‘One way in which sociologists might profit from paying closer attention to the historical method is to acquire a sharper sense of the relationship between social events over time. In order to appreciate how the institutions we study are moulded by the passage of years, we probably need to learn how to think in narrative terms, to develop a feeling for the temporal nature of social forces; and the only way we are likely to attain these skills is to become more ‘historical’ ourselves’ (Drake 1973: 26).

The main forms of data collected by the author through the period of time since 1999 up to the present is summarised in Table 4.1 below:

**Table 4.1: The main forms of data collected by the author**

Type of data	Sample size	Location and period of time
Questionnaire survey in Komi region within the INTAS-project	149 practitioners	Komi region. January 2001 – May 2001
In-depth interviews with managers (head doctors and head of departments in Komi region)	20 interviews	The capital of Komi region, Syktyvkar.  November-December 1999; May 2001
In-depth interviews with the heads of major alternative professional associations	19 interviews	Moscow. January – March 2003
Archival documents	–	Moscow. 1999-2003
Statistics	–	Moscow, Komi region. 1999-2003
Doctor's Newspaper ( <i>Vrachebnaya gazeta</i> )	–	Moscow. 1999-2003

In addition to these sources of data, in-depth interviews were carried out with two ex-Ministers of Health of Komi region, one of them still held a post during the period of the research. In Moscow, two people participated from the Ministry of Health of the Russian Federation (see Appendix 3). These interviews helped the author to understand state politics better and allowed explanations to be put forward for a set of events which had remained unclear after the research on medical practitioners.

## **2. Theoretical considerations involved in a multi-method approach**

A multi-method approach was adopted to tackle the research problems addressed in order to provide a more in-depth understanding of particular issues (Burgess 1981). Hammersley argues that qualitative research is sometimes regarded as being better able to produce information about interactional processes and about the perspectives of participants, whereas quantitative research is presumed to be better at documenting



frequencies and causal patterns (Hammersley 1995). A further theoretical justification for combining quantitative and qualitative approaches is as a strategy which provides a solution to what sociological theorists term 'the duality of structure' (Giddens 1984), which refers to the macro-structural ways of understanding society which tend to call forth a deterministic explanatory mode, versus those micro-structural approaches which emphasise creative and interactive explanation and processes (Brannen 1995: 16). Quantitative research is especially efficient at getting to the 'structural' features of social life, while qualitative studies are usually stronger in terms of 'processual' aspects (Bryman 1995: 60). It is not possible to 'dissolve' the micro/macro dimension, unless two different theoretical frameworks are addressed through different methods. In the thesis, rather than choose one side of this polarity, this author looked at both 'structure' and 'meaning'. As Hammersley comments:

'We are not faced, then, with a stark choice between words and numbers, or even between precise and imprecise data; but rather with a range from more to less precise data. Furthermore, our decisions about what level of precision is appropriate in relation to any particular claim should depend on the nature what we are trying to describe, on the likely accuracy of our descriptions, on our purposes, and on the resources available to us, not on ideological commitment to one methodological paradigm or another' (Hammersley 1992: 163).

A number of social researchers have asserted that quantitative and qualitative methods can be used effectively in the same piece of research and that quantitative data can be used to validate qualitative analysis through the process of 'triangulation' (Denzin 1978; Strauss and Corbin 1990). However, in the thesis research, the combination of qualitative and quantitative research design was not used as a method of 'triangulation' (Denzin 1978), at least not in the sense of using one part of the study simply to check the validity of the other part. It has been frequently noted that the assumption that combining approaches ensures the validity of data is naïve (Bryman 1984; Fielding and Fielding 1986; Hammersley and Atkinson 1995). Tensions arise with respect to differing types of explanation and the nature of data itself. In the research, given that each part yielded data on different phenomena, it could not have been done in any case. However, the two-stage design certainly was intended to enhance the validity of the overall analysis, precisely by producing data on different aspects of professionalisation of orthodox and alternative practitioners, so that the author could build up a credible overall picture (Mason 1995: 104). During the research, the dominant themes emerging

from quantitative and qualitative were sometimes in conflict, but the intention was to use such occurrences as a way of identifying possible points of dissonance or a variety of interpretations assembled from those with different perspectives (Fielding and Fielding 1986).

Besides 'triangulation', Creswell (1994: 112) advanced the following practical purposes for combining qualitative and quantitative methods in a single study: (1) complementarity, in that overlapping and different facets of a phenomenon may emerge; (2) a developmental approach, wherein the first method is used sequentially to help inform the second method; (3) initiation, wherein contradictions and fresh perspectives emerge; and (4) expansion, wherein the mixed methods add scope and breadth to a study. These were taken into consideration during all phases of the research. Moreover, using a multi-method approach, an attempt was made to meet some of the criticisms advanced against the use of questionnaires in the collection of data. Feminist methodologists, for example, argued that their use imposes rationality on experiences which in reality may be ambiguous and chaotic (Sapsford and Abbot 1992). So there is a danger that the imposition of interpretative frameworks of researchers through the use of pre-coded questions can often give a form and order to accounts that is deceptive. However, a combination of quantitative and qualitative methodology can take into account the need for participants in the research to help frame the issues rather than being seen as mere respondents.

Brannen argues that the multi-method approach demands that the researcher specifies the particular aims of each method and the nature of the data expected to result (Brannen 1995: 16). According to her, there are three main ways in which those researchers who have drawn on both qualitative and quantitative methods in their work have combined them: qualitative work as a facilitator of quantitative work; quantitative work as a facilitator of qualitative work; and studies where both approaches are given equal emphasis. These are combined in the research process according to several factors (Brannen 1995: 23-26). The first factor concerns the relative importance that is given to each approach within the overall project. The second concerns time-ordering – the extent to which methods are carried out consecutively or simultaneously. Thus, the contribution of qualitative methods to the formulation of a theoretical problem which a survey then goes on to address requires that intensive fieldwork be performed prior to the survey. Moreover, if the purpose of the qualitative fieldwork is to clarify or extend a



survey finding, then it must be conducted after the survey. Throughout this research, quantitative and qualitative approaches did not proceed alongside one another. In general they addressed different but associated questions so that two types of data complemented each another.

In the first stage of the research, drawing on the INTAS project, a quantitative methodology was the dominant tool for investigating the dynamics of social status and professionalisation process of orthodox doctors. The qualitative methodology was used as a 'facilitator' of quantitative work (Bryman 1984; Brannen 1995). First, it helped in the development and piloting of research instruments before the survey. It was used in the piloting of the questionnaire, namely the trying out of questions and the development of codes with which to categorise responses. It also helped in the identification of the key concepts and their operationalisation within a quantitative paradigm. Second, qualitative research was used after the INTAS questionnaire survey to interpret and clarify findings, which the quantitative data could not explain, and to follow up some issues in a way where it was inappropriate to apply quantitative methods.

In the second stage of the thesis research which dealt with the professionalisation processes of alternative practitioners, a qualitative method became the dominant one. The quantitative data from the INTAS research was used as a facilitator for the qualitative work which helped to contextualise the small scale intensive study. The data from the INTAS research and official statistics, such as census data, also served to provide an understanding of the scope of alternative practice undertaken by orthodox practitioners, their referral patterns to alternative practitioners and their attitude towards the integration of alternative medicine into the state sector. The two stages of research are discussed more fully below. In each section, particular aims of each method are specified, the nature of data that was expected to result, and how the data related to theory.

### **3. The first stage of the research: data collection and analysis relating to orthodox Russian doctors**

#### **3.1. Research design**

The INTAS research aimed to investigate the background, work situation, and the attitudes and values of medical practitioners in contemporary Russia. This thesis drew on selective findings of the INTAS research that dealt with the understanding of the dynamics of the social standing of Russian orthodox medical practitioners (namely power, income and prestige) and their professionalisation process. Thus, two things were of particular interest. First, whether Russian doctors felt they exercised autonomy in the work place, whether they looked to their medical colleagues for support and whether they belonged to professional associations and used these to protect their interests. In Anglo-American sociology, these are taken as attributes of professional practice (Freidson 1994). Second, the economic resources of doctors were investigated: their sources of income, particularly from private practice. The analysis was done on the basis of (1) the view of medical practitioners of the effects that health insurance system and privatisation had on the budgets of their medical institutions and the conditions within them, and (2) their self-assessment of financial position, career and life chances. Linked to these questions, the INTAS research considered whether doctors believed that others valued their expertise.

Within the INTAS-project, the research undertaken for the thesis had four major components: (1) documentary research; (2) qualitative in-depth interviews with twelve doctors in Komi region before the questionnaire research; (3) quantitative questionnaire survey of over 600 Russian doctors in three regions; (4) focused qualitative interviews with eight doctors from Komi region, who responded to the quantitative survey, and were selected to explore the issues raised in the quantitative research (The list of medical institutions from which the interviewees were drawn is given in Appendix 2). The quantitative data were self-administered, whereas all the qualitative data were administered in an interview format face-to-face with individuals. There were significant advantages of drawing on the initial INTAS pilot data, due to the richness of the data collected, and the ability to identify significant attributes of Russian doctors from a small group of medical practitioners (Babbie 1990). As was indicated above, in



the first stage of the research, quantitative methodology was accorded the greatest significance. A qualitative methodology was used to complement the quantitative work, and the findings of the interviews were incorporated in the piloting and writing up phases of the research. They will be referred to separately, where it is relevant.

The survey data were collected in several phases. The first draft of the questionnaire with the exception of section IV and VI was developed by this author under the supervision of Professor Mansurov<sup>13</sup>. The joint team of researchers, including Professor Allsop (De Montfort University, UK), Professor Saks (Lincoln University, UK), and Dr Kauppinen (the Institute of Occupational Health, Finland) helped the Russian team to develop the questionnaire design and, in the subsequent data analysis, to draw on a theoretical framework developed from the Anglo-American sociology of the professions and social stratification theory. The questionnaire, the main data collection instrument, was piloted in the summer of 1999 in Komi region, which involved in-depth interviews with medical administrators. These interviews contributed to the second phase: the final design of the questionnaire in Autumn 2000 at De Montfort University and its administration. A purposive sample of doctors within the three regions was identified, and a self-administered questionnaire survey was carried out by the Russian researchers between January 2001 and May 2001. In all, 605 self-completed questionnaires by doctors from three different Russian regions were returned, which slightly exceeded the target figure of 600 returns.

### **3.2. Sample size and representativeness**

The research project was based in three regions within Russia so that comparisons could be made in the responses of doctors in different areas of the Russian Federation. The case studies were in Moscow, the capital, and a dense urban area, Kirov, a provincial machine-building city to the east, and Komi region, an area dominated by coal-mining, oil and gas well to the north of the capital<sup>14</sup>. The regions selected as the focus for the research did not represent Russia as a whole, but were typical of the regions in which the process of privatisation had been relatively well developed and insurance reforms had already had an impact on the differentiation of the social standing and attitudes of the medical practitioners. In the research, the difference between Moscow which was

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<sup>13</sup> Sections IV and VI were developed by Dr Plotnikov.

<sup>14</sup> In Kirov, the questionnaire survey was undertaken by Dr Plotnikov and researcher Reztsov. In Moscow, it was undertaken by senior researchers Epihina and Zobina.

expected to be in the vanguard of reforms, and the provinces which were considered to lag behind as far as changes were concerned were reviewed (Reshetnikov 2002). The hypothesis was that there would be differences between the working conditions and attitudes of doctors in the capital and those in the provinces, for the simple reason that Moscow was characterised by the concentration of financial capital, highly qualified medical help, and higher income. In contrast, Komi region and Kirov were quite typical Russian regions with an average proportion of the medical practitioners, an average income of the population and diverse quality of patient care (Reshetnikov 2002). The inclusion of the two provincial Russian regions also provided an opportunity to question doctors from rural as well as industrial areas.

The requirement that the sample be representative of Russian medical profession had to be offset against resource considerations. Thus the major principle that underlay the sample design was to achieve the maximum precision for a given outlay of resources. This being the case, the choice was made for a pragmatic non-probability quota sampling method, under which a method of stratified sampling in which the selection within a stratum is non-random was understood (Russell 2000: 174). Stratification was done according to the form of ownership of medical institutions. Then non-random samples of medical practitioners were taken within each stratum, according to specific characteristics (gender, medical specialty and administrative position). These characteristics were represented in such a way that they reflected the characteristics of the Russian medical profession (Creswell 1994: 120). The process of the formation of sample is discussed more fully below.

Initially, the medical institutions were divided into a number of strata, according to the form of ownership, – ‘state’ institutions, ‘state with fees-for-service’ and ‘private’ ones. At the starting point of the research three types of medical institutions were distinguished, as it was anticipated that they would operate in rather different ways and provide medical practitioners with different opportunities. It was easy to stratify the medical institutions in Komi region where the distribution of the medical institutions with respect to the form of ownership was known. In Kirov and in Moscow, a problem was encountered with the availability of the medical statistics. The collapse of the Soviet system saw fundamental changes in the collection and provision of statistics, including those relating to the employment in the health sector (Clark 2002). Thus the



research team was unable to obtain a general list showing the distribution of the medical institutions as far as their form of ownership was concerned. Therefore to do prior stratification, the researchers relied heavily on the interview material, and the opinion of those interviewed on the distribution of the medical institutions within the state and private sectors. Table 4.2 below shows the private-state ratio in the sample:

**Table 4.2: The ratio of state/state with fees-for-service/private medical institutions in the sample**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
Type of the medical institution	State	56	70	66	62
	State with fees-for-service	15	28	33	23
	Private	28	2	1	15
	DK	1	0	0	1
	Total	100	100	100	100

Within the medical institution medical practitioners were stratified according sex, medical specialty and administrative position. An effort was made to reproduce the same proportion of items in each stratum which was characteristic of Russian medical practitioners in general. First, it had to be taken into consideration that the majority of Russian medical practitioners were women. In 1998, 68% of Russian doctors were women, 32% were men (Harden 2001: 188). Thus, to reproduce the given proportion, out of each ten doctors seven women and three men were sampled. Table 4.3 below shows that a representative sample of men and women in the quota sampling was secured.

**Table 4.3: Sex division of the sample**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
Sex	Men	27	37	34	31
	Women	73	63	66	69
	Total	100	100	100	100

As far as stratification according medical specialty was concerned, our hypothesis was that general practitioners and medical specialists needed to be analysed separately. The semi-structured interviews undertaken in Komi region showed that there was a disparity between the social status of general practitioners and medical specialists. The former, mostly employed within the primary care sector, had suffered the greatest drop of their social standing. The medical administrators interviewed said that with regards to the

money and medical equipment, hospitals had larger allocations than the polyclinics, which had serious problems with attracting and keeping labour. So in the research, two groups were singled out: the general practitioners and the medical specialists. In the latter specialists in paediatrics, obstetrics, gynaecology, psychiatry, hygiene, and epidemiology were included. Subgroups of medical specialists were not analysed separately as they were small in number and would not have been representative of all members of a certain specialty. As the composition of medical practitioners according to their specialty was not known, it was decided to secure an approximate correlation of fifty percent of general practitioners to fifty percent of medical specialists as shown in Table 4.4:

**Table 4.4: Medical specialty distribution in the sample**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
Medical specialty	GP	52	47	52	51
	Medical specialty	48	53	48	49
	Total	100	100	100	100

In the research a third fundamental distinction was made between rank-and-file doctors and medical administrators, the so-called ‘head doctors’. Although the latter were also professionally trained doctors, their position in the medical institution was quite distinct as they enjoyed larger decision-making powers and they were less involved in day-to-day practice. Some of them had withdrawn from medical practice altogether. The questionnaire survey covered all the categories of doctors: rank-and-file practitioners, heads of departments and head doctors. The latter two groups were united into one category of ‘medical administrators’, as the pilot research in Komi region had shown, they had similar attitudes and were influential within their own medical institution. The most important distinction between head doctors and head of departments was that the latter did not leave their medical practice and when they became administrators, they had less involvement into the issues of medical institution management. In each medical institution, no more than two or three representatives of the medical administration were sampled. Table 4.5 shows the distribution of administrative positions of doctors in the sample.



**Table 4.5: Administrative position in the sample**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
Administrative position	Medical administrators	22	26	25	24
	Rank-and-file doctors	75	72	68	73
	Other	3	2	7	3
	Total	100	100	100	100

In the analysis which follows in subsequent chapters, the above-discussed sub-samples (according to the geographical region of research and stratifying characteristics of respondents) are referred separately, as appropriate. The cluster of questions identifying key characteristics of respondents also included such characteristics as age, the length of service in medical specialty, and the category (level of qualification, which specifies distinctions of doctors in Russia).

### 3.3. Instrumentation

Data were collected by means of a questionnaire containing 79 questions (see the questionnaire in Appendix 4). The majority of these were Likert-type questions based on a scale from ‘a very small extent’ to a ‘very great extent’ (Likert 1932). Other questions asked for factual information or used categorical scales (yes/no). The pilot study in Komi region was important as it established the face validity of the questionnaire in that the questions actually measured what they purported to measure and helped to improve some questions (Borg, Gall and Gall 1996). The major content sections in the questionnaire were the following:

1. Personal characteristics of the respondents (sex; age; post-qualification studies; specialty; length of service; category; administrative position; membership in professional associations).
2. Medical institutions of the respondents (the form of ownership of a medical institution; various changes in the state of affairs in the medical institution since 1992).
3. Financial status of doctors (the importance of different income sources for doctors; their self-assessment of the current financial circumstances of doctors).

4. Attitudes towards the medical profession (factors that influenced choice of the medical profession; feelings about profession; the level of satisfaction with the profession; sources of dissatisfaction; opportunities for professional growth; the value of the medical profession in public opinion)
5. Privatisation of medicine (attitudes towards the privatisation of medicine and the introduction of compulsory and voluntary medical insurance funds)
6. Professional ethics (attitudes towards various ethical aspects of professional practice, including unofficial informal payments from patients, avoidable medical mistakes and medical negligence)
7. Alternative medicine (the practice of alternative medicine by orthodox doctors; attitude of orthodox practitioners towards referrals to alternative practitioners and the issue of the integration of alternative medicine into official state health care)

Issues that related to the professionalisation of orthodox doctors – namely, their power, income and status – were operationalised by this author. The operationalisation of the variables connected with the goals of the research is discussed below.

### **3.4. Operationalisation of the variables**

The main approaches to the phenomenon of ‘professionalisation’ have been outlined in the previous chapters. In Western countries, professionalisation is mainly understood as based primarily on the establishment of legally underwritten occupational monopolies in the marketplace, with all the ensuing privileges of income, status and power that they bring (Larson 1977; Macdonald 1995; Saks 2003a). Within the context of Russia, where the market for medical services is still at an early stage of formation and where state regulation is strong, it was suggested that a case for greater professionalisation could be demonstrated through an enhancement in the scope of power, and additional economic or cultural resources in the market or within the state sector. This could eventually lead to a drive towards a legally underwritten professional monopoly. Throughout the research, the term will be used to describe the corporate actions of the professionals to redefine the social characteristics of the profession within Weber’s dimensions of power, culture and wealth (Weber 1958).



A synthetic theoretical model that could be applied to the empirical study in Russia was thus developed that broadly followed a neo-Weberian approach. 'Social standing' was interpreted as a bundle of resources that open up different opportunities in the dimensions of power, economic status and prestige, or cultural resources, for those who practise medicine. Such resources are latent aspects of professional practice. This definition draws on Bourdieu's understanding of a person's social standing (or social position) as derivative from personal capital – economic, cultural or symbolic (Bourdieu 1990). A three-dimensional understanding of the social standing of medical practitioners in the dimensions of power, culture (prestige) and economic position is discussed in detail below.

### **3.4.1. Power resources**

The power resources of doctors were central to the analysis of the INTAS data. In the Anglo-American model, power resources derive from the exercise of professional autonomy in a number of spheres. A key aspect of autonomy in professional practice is the ability of practitioners to make decisions without external pressure from those who are not members of the profession (Freidson 1994). The scope of autonomy determines professional group opportunities in different social dimensions such as income, prestige, and interesting work. However, sociological analyses suggest that a key variable for medical professionals themselves and one considered central to maintaining professional autonomy is decision-making in the sphere of diagnostics and medical treatment. Freidson, for instance, comments that: 'the central issue of professional power lies in the control of work by professional workers themselves, rather than control by consumers in an open market or by the functionaries of a state' (Freidson 1994: 32). Obviously, professionals cannot be totally insulated from the effects of the state and the market. However, the professions in many Western societies have retained considerable scope for autonomous decision making – an aspect of 'self regulation' (Allsop 2002; Allsop *et al.* 2004) Other aspects of autonomy are the ability to determine conditions of work such as work plans and the pace of work.

A second important aspect of professional autonomy is the ability to influence the scope of remuneration by determining the quantity and quality of work done, and also the setting in which it is done, and for whom. In this respect, in the INTAS research we were interested in investigating whether both state-employed and private practitioners

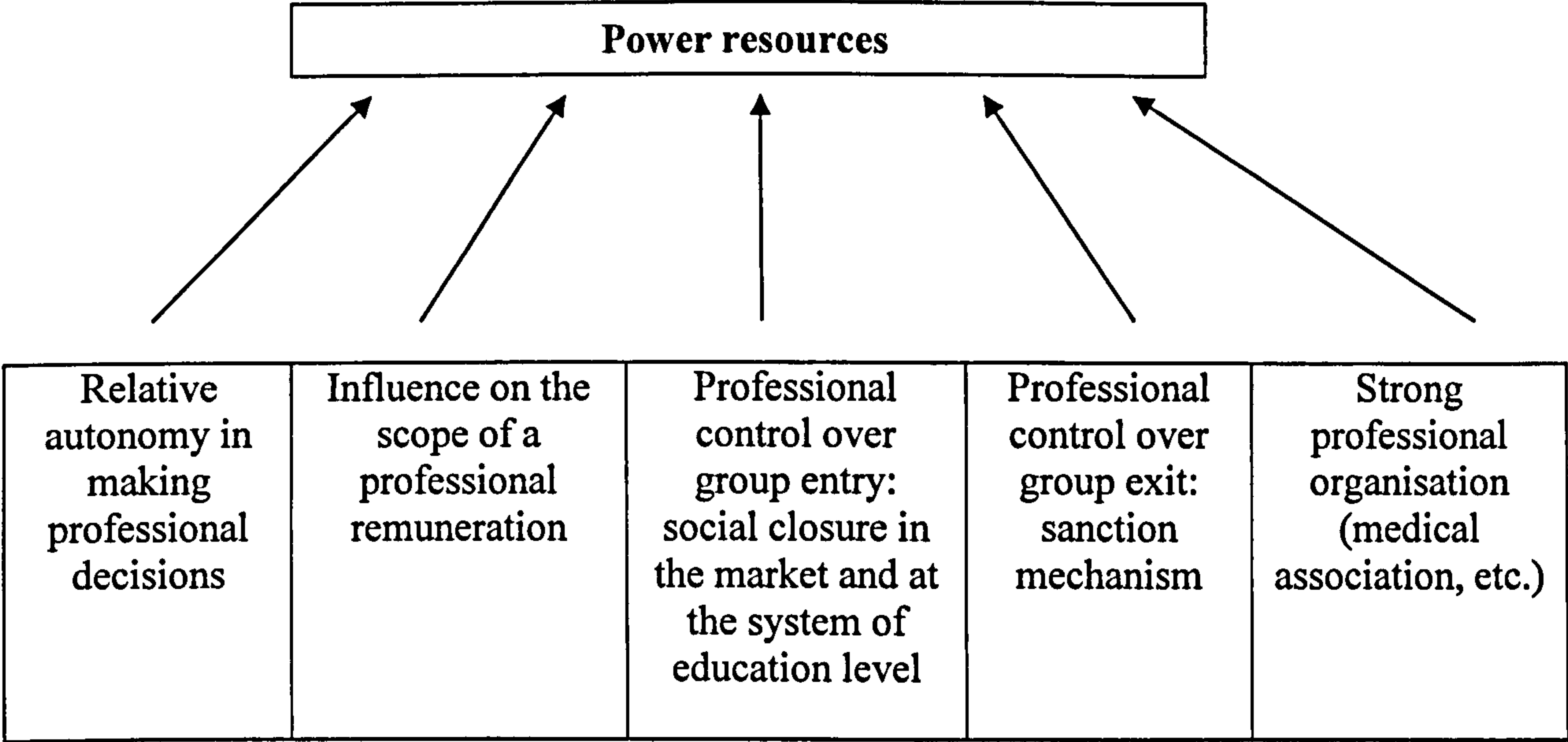
could influence their level of fees and how they achieved a balance between the two. An attempt was made to explore doctors' ability to set the price of services either directly or indirectly, and to influence wage levels, bonuses and allowance payments. The research also aimed to identify the scope for doctors to decide on a particular combination of state/private practice.

A third, and most crucial, indicator of professional autonomy is the extent to which an occupational group can control who enters the group and who is excluded (Larson 1990). It can construct access restrictions and filters into the professional group. A number of theorists in the Anglo-American tradition have used the notion of social closure to analyse this key aspect of a collective professionalising strategy (Parkin 1979). In Britain, a professional group may create a monopoly by determining who enters the education system and who is licensed to practise. The professional association, typically licensed by the state, determines who is admitted and who is not. Once established, strong professional associations have charters that regulate training and have rules that govern inclusion and exclusion and exercise a monopoly over certification, the creation and dissemination of expert knowledge and standards of practice. They control the 'production of producers' (Larson 1977).

Traditionally, professional groups determine the content of examinations; the terms, conditions and goals of education and training; and the numbers of 'recruits'. However, in practice in state-funded health and education systems, control over these areas tends to be shared between the profession and the state (Allsop 2002; Allsop *et al.* 2004). Typically, licensing boards are staffed with members of the profession or with people approved by the profession so that it is said to be 'self-regulated'. Professional associations establish both formal and informal types of quality control. This enables them to fulfil their obligation to protect the public – the condition for state licensed self-regulation. They are obliged to identify poorly performing doctors and if necessary, to exclude them from practice (see, for instance, Stacey 1992). Another mechanism for ensuring that the profession controls its own members is the maintenance and regular updating of an ethical code relating to professional practice. As far as is practically possible, the professional association should take steps to ensure that this is adhered to in day-to-day practice. The resources of power used to analyse the INTAS data are summarised in Figure 4.1 as follows:



**Figure 4.1: Professional power resources**



Clearly, in order to carry out these functions, the profession must have a concept of itself as a collectivity. The rank-and-file must accept professional leadership and the leadership will have to maintain the confidence of the membership when it represents its interests. In effect, the professional association becomes a political force in acting for its members. The questionnaire was designed to include questions that captured these different aspects of professional power within the context of Russian medical care practice, as it is shown in Table 4.6 below:

**Table 4.6: Questions on power resources**

Research Question	Item on Survey <sup>15</sup>
Autonomy in making professional decisions	Questions 20, 21, 22, 32
Influence on the scope of a professional remuneration.	Questions 20, 21, 22, 32
Professional control over group entry: social closure	Questions 20, 21, 22, 32
Professional control over group exit: sanction mechanism	Questions 20, 21, 22, 32
Strong professional organisation (medical association, etc.).	Questions 9, 10, 11, 46, 58, 67, 70

<sup>15</sup> See the INTAS-questionnaire in Appendix 4

**3.4.2. Economic resources**

The economic resources available to Russian medical practitioners were also investigated in the INTAS study. Two related issues were considered. The first was the financial position of the medical institution at which the doctors currently worked. The questionnaire included items on the following: how doctors themselves viewed the resources of the institution where they worked. How the institution had adapted to the introduction of compulsory and private medical insurance. Whether the medical institution that employed them provided services that carried charges, and if so, which fee-for-service it provided. Questions were also asked about the availability of standard technical equipment for clinical work and the supply and maintenance of such equipment as well as about the availability of routine medical supplies and the level and adequacy of the wages of doctors. In the research, these data were complemented by the documented evidence on the financial position of doctors from the Ministry of Health and the statistics available from the medical institutions of the respondents.

Questions were also raised about the financial circumstances of the medical practitioners themselves – that is, how they rated the scope of their fees and their quality of life in general. The strategies of doctors for adapting to difficult financial circumstances were of particular interest to the researchers: how they supplemented their earnings through, for example, social security benefits, rent from housing, help from relatives and interests from savings, and what their earnings from private practice and other sources were. All these questions were captured in the questionnaire, as it is shown in Table 4.7 below:

**Table 4.7: Questions on economic resources**

Research question	Item on Survey <sup>16</sup>
The financial position of medical institution	Questions 15, 16, 17, 18, 34, 48, 49
The financial circumstances of medical practitioners	Questions 19, 23, 24, 32, 45

<sup>16</sup> See the INTAS-questionnaire in Appendix 4



### 3.4.3. Cultural resources

The cultural resources of doctors as an occupational group were also considered important. 'Cultural resources' were defined as those that derived from the specialist cognitive knowledge base of medicine (Bourdieu 1990). Drawing on the Anglo-American sociology of professions, professional expertise drawn from an ever developing and complex theoretical base was seen as a significant characteristic of the profession (Abbott 1988). Public acceptance of professional authoritative advice was seen as crucial in determining whether an occupation could be called a profession. In the questionnaire, an attempt was made to find out whether Russian doctors believed that their knowledge was valued and whether it was an important source of their respectability.

Moreover, medical practitioners in most countries of Europe and North America have managed to transform their work into a 'status' profession. Weber argued that status communities are organised for the defence of their social privileges and entitlements. Status groups depend crucially upon the maintenance of a life style, and they seek to reproduce themselves through educational mechanisms, in order to prevent the social mobility of outsiders. In the questionnaire, Russian doctors were asked whether they believed that the occupation of medicine had a positive image, whether medical practice could be seen as an economic 'good' capable of generating resources and attracting business, and what their attitudes towards the importance of the outward signs of respectability were.

Professional altruism, taken as a social good at which the professional expertise is directed, was seen as an important characteristic of professionals by social researchers writing from a functionalist perspective (Goode 1960; Parsons 1968). Following the functionalist and trait writers, professionals are supposed to see their work as a kind of mission or calling. Unlike people whose work was considered to be an occupation, and who were taken to lack the feeling of 'commitment' to their work activity, professionals were assumed to remain committed to an area of work during their life span. Members of the profession were less willing to leave an occupation, and were more likely to assert that they would choose the same work if they were to begin again. In the questionnaire, Russian doctors were asked about the issues related to professional altruism. There was also an attempt to find out whether they were sufficiently well

motivated to exercise influence over those who used their services and the wider society. These issues were covered in the questions summarised in Table 4.8 below:

**Table 4.8: Questions on cultural resources**

Research question	Item on Survey <sup>17</sup>
Value of professional expertise. Prestige of the profession	Questions 25, 31-40, 43-45, 47
Professional altruism	Questions 50-53, 59-63, 66-72

**3.5. Management and analysis of data**

A database for the questionnaire data was designed using Statistical Package for the Social Sciences for Windows (SPSS) and set up prior to the research. The questionnaires were coded by senior researchers Epihina and Zobina<sup>18</sup> from the Institute of Sociology (Moscow). When the transcribing of open questions and commentaries of respondents and the cleaning of pre-coded data were complete, the questionnaires were shredded as a way of guaranteeing confidentiality (as suggested by Mathers *et al.* 2000). The next stage of analysis involved the categorisation and coding of qualitative data supplied by respondents in the open questions of the questionnaire. Separate ‘write-in’ files were created to record all the additional qualitative data supplied by respondents in the spaces left for open-ended questions. This allowed the data to be sorted and re-sorted.

Frequency tables produce a valuable source of descriptive data (George and Mallery 2000). In general, quantitative research relies on enumerative induction, that is the strength or validity of a generalisation is inferred from the number of instances occurring (Ernis 1968: 523). Frequency scores, percentages, and averaging are used throughout forthcoming chapters in order to present key findings from the INTAS research that relate to the aims of this thesis. Care was also taken to achieve consistency in interpreting the data by using pre-set guidelines on frequencies deemed high enough for comment. For example, most specialties contained fewer than 30 consultants, and therefore they were united into two categories of ‘medical specialties’ and ‘generalists’.

<sup>17</sup> See the INTAS-questionnaire in Appendix 4  
<sup>18</sup> These researchers also participated on a par with this author in the process of producing frequency tables and cross-tabulations with the aid of SPSS.



Separate specialties (e.g. cardiologists or neurologists), although of interest, were not used to support generalised comments, as their numbers were small. Frequency distributions revealed much that was of interest but did not produce information on the relationships between variables (Blaxter *et al.* 2001). The next stage of data analysis was to explore the correlation between pairs of variables through the production of a series of cross-tabulations. Then a number of inferences were generated by the British and Russian team of researchers. This method of analysis made wide use of proportions and percentages and plotting of tendencies. These data were used to produce a series of commentaries discussed selectively in the chapters that follow.

## **4. The second stage of the research: data collection and analysis relating to Russian alternative practitioners**

### **4.1. Research design**

Qualitative research was the main component of the second stage of the research for the thesis. It was complemented by some data from the INTAS-project and some factual information from official documents, such as newspapers and statistics<sup>19</sup>. It has been argued that qualitative research has the advantage of being able to obtain data not possible with quantitative methods such as structured surveys, which collect standardised information from each respondent (Hammersely 1995). Quantitative techniques are ideal for research studies attempting to gain a great breadth of information rather than in-depth data. A distinction can be made between quantitative methods where generally a small amount of information is collected from any one individual, contrasting with a qualitative study where a great deal of information may be obtained from particular 'key informants' (Robson 1993: 49).

Since the publication of Glaser and Strauss' influential book *The Discovery of Grounded Theory* (1967), qualitative researchers have discussed whether the purpose of theoretical studies should be to *develop* or *verify* social theory, or both (see for example, Strauss and Corbin 1990). Glaser and Strauss argue that qualitative and other social science researchers should direct their attention to developing or generating social

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<sup>19</sup> During the second stage, quantitative data was subsidiary and will not be commented separately.

theory and concepts. However, other researchers, writing from a more positivistic stance, take the position that qualitative research, just like quantitative studies, can and should, be used to develop *and* verify or test propositions about the nature of social life (Taylor and Bogdan 1998: 136). The procedure of *analytic induction* has been the principal means by which qualitative researchers have attempted to do this (Katz 1983).

The second stage of the research is based on analytical induction. Katz has characterised analytical induction, which he refers to as ‘analytical research’, as a rigorous qualitative method for arriving at a perfect fit between the data and explanations of social phenomenon (Katz 1983). The steps involved in analytical induction are relatively simple and straightforward as follows (Katz 1983: 131; Taylor and Bogdan 1998: 139):

- The development of a rough definition of the phenomenon to be explained.
- The formulation of a hypothesis to explain that phenomenon, which can be based on data, other research, or the researcher’s insight and intuition.
- The study of one case to see the fit between the case and the hypothesis.
- If the hypothesis does not explain the case, either reformulation of the hypothesis or redefinition of the phenomenon.
- The search for negative cases to disprove the hypothesis or redefine the phenomenon.
- The continuation of the procedure until the hypothesis has been adequately tested by examining a broad range of cases. According to some researchers, the research should go on until a universal relationship has been established.

Analytical induction has been criticised for failing to live up to the claims of its early proponents as a method for establishing causal laws and universals (Znaniecki 1934; Turner 1988). However, the basic logic underlying analytical induction can be useful in qualitative data analysis. As Taylor and Bogdan claim, by directing attention to negative cases, analytical induction forces the researcher to refine and qualify theories and propositions (Taylor and Bogdan 1998). Katz (1983: 133) argues:

‘The test is not whether a final state of perfect explanation has been achieved but the *distance* that has been travelled over negative cases and through consequent qualifications from an initial state of knowledge. Analytic induction’s quest for perfect explanation, or ‘universals’, should be understood as a strategy for research, rather as the ultimate measure of the method’.



In contrast to the grounded theory approach, analytical induction also helps researchers address the question of generalisability of their findings. If researchers can demonstrate that they have examined a sufficiently broad range of instances of a phenomenon and have specifically looked for negative cases, they can assert greater claims regarding the general nature of what they have found (Taylor and Bogdan 1998: 139-40).

In summary, the second stage of the thesis research was directed towards developing in-depth understanding of the professionalisation of Russian alternative practitioners. As Hammersely argues, analytical induction may combine an inductive logic of inquiry, which begins with an absence of clear hypotheses, with deductive methods, namely the testing of hypotheses (Hammersely 1995). This was true of the research undertaken for the thesis, where analytical induction had some parallels with the grounded theory method of Glaser and Strauss (1967), as some insights were grounded and developed from the data themselves. In contrast to Glaser and Strauss, however, the author was less preoccupied with developing new concepts and theories from the data than with trying to apply the Anglo-American concepts of professionalisation in the Russian context and to verify whether the concepts were adequate to describe the Russian situation. The Anglo-American theories were used to illuminate features of the settings and people under study and to aid understanding. The research aimed at the systematic search for generalisations entailed in analytical induction.

## **4.2. Sample and representativeness**

As Brannen argues, the idea of qualitative research is to purposefully select informants who are in the best to answer the research questions (Brannen 1995: 9). In so far as qualitative methods are employed on non-statistical samples, sampling may be conducted on the basis of theoretical criteria. The basic question in 'theoretical sampling' concerns which case, or group, to turn to next in the analysis and with what theoretical purpose (Strauss and Corbin 1990). Sampling continues until the point at which additional data do not appear to provide further insights in developing or verifying theory. This is known as 'theoretical saturation'. In the research, a balance was struck between the point of theoretical saturation and the availability of time and money resources.

During January to March 2003, the author interviewed nineteen prominent alternative practitioners: heads and deputy heads of eight large professional associations and rank-and-file members of these associations, who were well-renowned and known throughout the country. Among the experts there were representatives of almost all major Moscow and All-Russian associations located in the capital, and two interviews were undertaken with the officials of the Ministry of Health of the Russian Federation. As a result in the sample, there were respondents from the following alternative medicine associations (the list of names of the experts and their administrative positions is given in Appendix 3):

- The Moscow Professional Society of Osteopaths; the League of Professional Osteopaths; the All-Russian Medical Association of Osteopathy.
- The All-Russian Homoeopathic Association; the Moscow Association of Homoeopathy.
- The Professional Society of Acupuncturists.
- The Society of Medical Herbalists.
- The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers.

The first experts were found through the reference book *Who is Who in Medicine and Health in Russia* and through Internet data. Then a snowballing technique (Maslennikov 2001: 120) was used: respondents recommended prominent representatives from other professional associations of alternative practitioners. All the interviews were carried out in the place of work of those interviewed. Sometimes this settings entailed restrictions on the time available and privacy. However, the settings were chosen by interviewees, most of whom were overworked and were not ready to be interviewed elsewhere.

The opinion of the heads of the professional organisations who participated in the interview research was taken to represent the views and attitudes of the members of these professional organisations. The author admits that rank-and-file members may have a different opinion on the best way for the development of their association. However, with regard to the issues of generalisability (Maxwell 2002: 52), the accounts of leaders of professional associations were taken to broadly represent the views of rank-and-file members. This was justified by several factors. First, rank-and-file doctors often formally approved of the actions of their leaders – as indicated by signed official



collective letters to the Ministry of Health and supported resolutions of the association (see, amongst others, Vasilenko 2002; Sitel 2003). Second, membership of these organisations was voluntary, and if practitioners belonged to a professional organisation it was assumed that they supported its leaders, who were regularly re-elected. As suggested by Freidson (1975: 272-73), the author was less concerned with describing the range of variations between the opinions of alternative practitioners than with describing in detail what quantitative methodology would not have permitted to describe – the general assumptions, behaviour, and attitudes of alternative health practitioners.

#### **4.3. The researcher's role**

The alternative practitioners interviewed enthusiastically welcomed the research. Many of the respondents mentioned that they were ready to publish the findings of the survey in their professional journals. Nevertheless, half of the respondents refused the dictaphone, and the author had to make notes. The reason for this caution had to do with several factors. First, as Harden justly comments, there has been a general lack of familiarity with interview research in Russia (Harden 2001: 184). Sociological studies in Soviet Russia have tended to be almost entirely quantitative, although this is now changing. Second, alternative practitioners still have a marginal position in the Russian state health care, and therefore attribute great importance to good relations with the Ministry of Health, which remains the main regulating body in the Russian health sector (Reshetnikov 2002). Despite the fact that all interviewees belonged to the therapies that had received state registration, they said that they still did not fit well into the state health sector, and their rights and obligations were not well defined. Indeed one expert – a titled alternative and orthodox professional, a respected Doctor of Medicine – warned me that if the information that he had shared with me leaked out into the Ministry of Health, he would deny that we had an interview. A few interviewees explained that their professional associations worked actively for the enhancement of their rights and change in their social position, and they were aware of everything which could further their interests or hamper their progress.

From the start of the research, most experts asked whether as a researcher I was sympathetic to alternative medicine in general and their therapy in particular. I could not abide by conventional interviewing guidelines, and in order to gain the trust of

respondents I had to engage in normal conversations and assure the interviewees that I was well-disposed to alternative medicine. There has been a debate in the sociological literature about the degree of empathy required to build trust and rapport with the respondent in a qualitative research (Silverman 2000). However, in this case to do otherwise would have meant inhibiting the degree of rapport with interviewees. For example, one expert angry at the national newspaper's editorial on alternative medicine emphatically titled 'Black Death of the Twenty First Century' (Moskovkii Komsomolets 2003), refused to give an interview until he believed I was sympathetic towards alternative medicine and naturopathy. The second question asked frequently by the alternative practitioners was whether I was on the staff of the Ministry of Health, as most respondents had a difficult relationship with the ministerial officials. I always expressed loyalty towards alternative medicine and gave assurances that confidentiality of the data would be maintained, and the research would be used for the intended purposes (Mauthner *et al.* 2002).

#### **4.4. Instrumentation**

These in-depth interviews on average lasted about an hour and a half. Interviews were recorded by taking notes and some were audiotaped. Audiotaped interviews were transcribed later. During the interview, the author took notes in the event that the recording equipment failed. The conversations on a topic were semi-structured: the author only followed the general outlines of the initial interview plan. No interview can be totally unstructured but attempts were made to encourage an informal atmosphere and to model the interaction on a conversation (Blaxter *et al.* 2001). The order of questions and their wording varied. A guide containing key issues was memorised so that constant reference did not have to be made to it. In many interviews respondents spontaneously addressed these issues without being prompted or asked.

The interviews allowed the identification of problems and perspectives of the professionalisation process of alternative medicine. Core issues discussed at interviews with alternative practitioners were the following, although the order of topics was not predetermined:

- Interviewees' understanding of the cause of the revival of alternative medicine.



- Their understanding of, and preferences for, the terms: ‘alternative’, ‘complementary’ and ‘traditional medicine’.
- The experience of interviewees of the impact of the state medical authorities on the development of alternative medicine.
- The extent to which alternative medicine is marginalised in official health care by the example of their specialty.
- The handling of marginal social position and the relationship between leaders of professional associations and rank-and-file doctors in the handling of this marginality in health care.
- The role played by the state in enhancing or in hampering the progress of professionalisation of alternative medicine.
- The extent to which the professional association is involved in professionalisation.
- The issues of trust of orthodox practitioners towards alternative medicine and of further integration of alternative medicine into the state sector.
- The main goals of the professional association and the dilemma of further integration into the state sector as opposed to achieving a legal monopoly in the market.

As discussed in previous chapters, the term ‘professionalisation’ does not exist in the Russian language. For this reason, and for simplicity, a definition of ‘professionalisation’ was provided for interviewees. This was described as the corporate actions of professionals in a particular area of work to redefine the social characteristics of their profession within the dimensions of power, culture and wealth.

#### **4.5. Validity and reliability**

In qualitative research validity has to do with description and explanation, and whether or not a given explanation fits a given description, if it is credible (Janesick 1998: 50). Merriam argues that qualitative researchers have no single stance or consensus on addressing validity and reliability in qualitative studies (Merriam 1988). In the research, this author followed the categories of validity suggested for qualitative research by Maxwell: (1) descriptive validity; (2) interpretative validity; and (3) theoretical validity (Maxwell 2002: 45). Descriptive validity relates to the concern of most qualitative researchers – that is with the factual accuracy of their account. Wolcott argues that

social researchers need to be sure that they do not make up or distort the things they saw and heard (Wolcott 1990a: 27). In this thesis, accurate description was the foundation upon which the research was built. The author recorded as accurately as possible, and in precisely the words of interviewees which were judged to be relevant.

In contrast to descriptive validity, which could apply equally well to quantitative and qualitative research, interpretative validity has no real counterpart in quantitative validity typologies (Maxwell 2002: 48). Qualitative researchers are also concerned with what certain objects, events and behaviour *mean* to the people engaged in, and with, them. To achieve interpretative validity in the research, the author tried to take into account what might be broadly termed as ‘perspectives of interviewees’. The author did not direct the interviewee by guiding or probing but allowed the subjects to talk as freely and spontaneously as possible. This was viewed as a prism through which to understand the experiences of interviewees and their attitudes to issues under investigation (Silverman 2000).

The two previous type of understanding of validity are ‘experience-near’ in Geertz’s sense, as they are based on the immediate concepts employed by participants (Geertz 1973). Theoretical validity goes beyond the concrete and descriptive and concerns itself with the constructions that researchers apply to, or develop from, a certain theoretical perspective. Maxwell argues that theoretical validity is a more abstract analysis than the descriptive and interpretive validities concerning the immediate physical and mental phenomena studied (Maxwell 2002). Indeed, the theoretical framework and the constructions of a researcher, whether grounded theory, analytical induction or another technique, intrinsically define both the recording and interpretation of the data at the initial stage of research. However, in the later stages, researchers need to identify their theoretical standpoint, and categorise their data accordingly. In this stage of the research, the author used a neo-Weberian approach to interpret the acquired information, which necessitated theorisation in the terms of social standing and professionalisation perspectives which have already been discussed above and will be presented fully in chapter VII.



#### **4.6. Management and analysis of data**

The data analysis was conducted as an activity simultaneously with data collection, data interpretation and reporting the results (Creswell 1994: 166). Following Marshall and Rossman, the process of qualitative analysis was based on data 'reduction' and 'interpretation' (Marshall and Rossman 1989: 114). They argue that the researcher takes a voluminous amount of information and reduces it to certain patterns, categories, or themes and then interprets this information by using some schema. Tesch called this process 'de-contextualisation' and 'recontextualisation' (Tesch 1990: 97). This process results in 'a higher level' analysis: while much work in the analysis process consists of 'taking apart' data into smaller pieces, the final goal is the emergence of a larger, consolidated picture.

A systematic process of analysing textual data was developed which involved identifying different categories. These were colour coded in transcripts. Useful quotes were singled out for incorporation into the thesis. As Schatzman and Strauss claim, qualitative analysis primarily entails classifying things, persons, and events and the properties which characterise them (Schatzman and Strauss 1973). Throughout the data analysis, this author sought to identify and describe patterns and themes from the perspective of the interviewees, and then attempted to explain these themes and patterns (Agar 1980; 1986). During the writing up period, a certain amount of counting instances within categories was implicit in the text using terms such as 'the majority', 'dominant', 'strong' to denote the strength of a category. Taped interviews were transcribed verbatim using Word for Windows. The author kept field notes and regularly reviewed them. As suggested by Merriam, a list of major ideas that surfaced was chronicled (Merriam 1988). With the help of computer, meaningful data was identified, retrieved, grouped and re-grouped for analysis and the findings are presented in chapter VII.

#### **5. The limitations of the research**

As was discussed, there are limits to generalisability of the research findings. The quantitative data from the INTAS-project cannot be generalised to the Russian medical profession in general. The three Russian regions, including Moscow, selected as the focus for the research did not represent Russia as a whole, but were typical of the regions in which the privatisation had been relatively well developed and insurance

reforms had already had an impact on the differentiation of the social standing and attitudes of the medical practitioners. However, the generalisations of the results were not intended to go beyond the scope of the study.

The results of a qualitative survey also have a limited generalisability. An attempt was made to extend the account of the opinion of the leaders of the professional associations of alternative practitioners to rank-and-file participants of these associations who were not directly studied. The author, however, admits that (1) some rank-and-file members may still have a different opinion on what the best way for development of their association may be; (2) the findings of the research cannot be generalised to alternative practitioners, who are not members of the studied professional associations. No claims for significance beyond these delimitations will be made.

Further, the research on alternative medicine could be extended to incorporate the analysis of the role of *illegal* lay alternative practitioners. As was discussed, only legal alternative practitioners – medically qualified doctors and the only one legal group of lay alternative practitioners specialising in ‘folk healing’ – were chosen as the focus of the research. However, in the folk sector, there are some full-time and part-time lay alternative practitioners specialising in alternative practices. To date, their numbers are small, and currently they are not united into any professional body. However, the analysis of their role and their potential to unite into a professional association to launch a professional project could become a subject for further research. The attitudes of legitimate medically-qualified alternative practitioners to their illegal lay counterparts may also become a subject for further investigation.

Finally, the methodologies adopted in the thesis could be used to assess the professional standing of alternative practitioners through a positivist methodology to generalise findings. In this research, interviews with alternative practitioners provided qualitative information only for doctors practising in Moscow. The quantitative standardised research could be extended to other Russian areas to look at regional differences and to generalise the findings of the interview survey. In contrast, quantitative research on orthodox practitioners could be strengthened by in-depth interviews in all of the regions of the research. This would give a chance to test the themes derived from the interviews in one of the regions of the research with a broader constituency.



## Conclusion

The purpose of this chapter has been to provide a link between the aims of the study and the empirical investigations undertaken. In the research, the objective was to verify the application of Anglo-American theories of professions and professionalisation to the Russian situation, and to describe the opportunities for the professionalisation of Russian orthodox and alternative practitioners. The research involved both inductive and deductive methods in the broad sense of these terms, so that the theories advanced in the previous chapters became something to test, and be developed and shaped in the process of the research. As highlighted, a multi-method approach was chosen to tackle the problems of the research. There was a need for information about both interactional processes and the perspectives of participants (the terrain of the qualitative research), as well as the documentation of frequencies and the identification of causal patterns (the terrain of the quantitative research). These mixed methods were used to add scope and breadth to the research. This chapter has sought to assure readers that data collection and analysis has been reflexive and rigorous, as well as to acknowledge its limitations. The chapters which follow present the analysis of the data collected and its relation to theory.

## V. THE PROFESSIONALISATION OF ORTHODOX MEDICAL PRACTITIONERS IN RUSSIA IN TRANSITION: PROCESS AND PERSPECTIVES

This chapter draws on selected findings from the INTAS-funded research project *Russian Doctors: Social Attitudes and Strategies for Adaptation* conducted by the joint team of researchers. The previous Methods and Methodology chapter provided information about the collection and analysis of data throughout the research. As was mentioned, this author actively participated in all the stages of the INTAS-project and carried out the fieldwork in Komi region independently. This included the questionnaire survey of 149 respondents and twenty interviews with head doctors and heads of departments of medical institutions, which were conducted prior to, and after, the quantitative research. The analysis of the data obtained from the INTAS-project presented in this chapter was done by the author under the supervision of research advisors: Professors Allsop, Saks, and Mansurov. These data were complemented by documentary research and the content analysis of the *Doctor's Newspaper* ('Vrachebnaya gazeta') undertaken from 1998 until 2003.

The main aim of this chapter is to analyse the changes in the social standing of orthodox medical practitioners and to explore whether social and political reforms have increased the potential for greater professionalisation. The chapter is in four parts. The first part of the chapter considers the reforms of the Russian health care sector: the decentralisation of the health regulations; the introduction of the compulsory insurance fund and the privatisation of medicine. These reforms are analysed from the perspective of new opportunities that they have opened for the professionalisation of medical practitioners. The second part of the chapter introduces the social attitudes of medical practitioners towards the health care reforms. It provides a foundation for better understanding of the attachment of Russian medical practitioners to the state sector and to the notion of socialised medicine. The third part of the chapter shows the dynamics of the social standing of medical practitioners in terms of the scope of their professional autonomy, their sources of income and cultural resources, such as professional prestige and the ideology of professional altruism. The fourth part of the chapter outlines the potential of medical practitioners to professionalise. It considers whether they look to their medical



colleagues for support and whether they belong to professional associations to protect their interests.

## **1. Reorganisation of the health sector: creation of opportunities for the professionalisation of the medical profession**

The political changes of the 1990s and the subsequent economic problems that occurred as Russia sought to restructure the economy have destabilised existing institutions. Russia has been through a period of rapid and dramatic change. When Gorbachev came to power in 1985 prices and wages were regulated from the centre, production and exchange were in accordance with centralised plan directives, and, apart from those working in collective farms, the entire employed population worked for the state (Gorbachev 1988). Most prices and wages were freed from central regulation at the end of 1991, and enterprises henceforth produced not for the plan, nor for the state orders with which Gorbachev had replaced plan targets, but for commercial sale (Clark 2002). The transition to a market economy had not brought with it the anticipated prosperity. Instead it brought unprecedented inflation; average real wages which had fallen to about the level of the late 1960s, before the “period of stagnation”; a doubling of wage inequality; a fall in total employment of around a quarter (Ashwin and Clark 2002). These political and social events themselves have been well documented and commented upon in general terms (see, amongst others, Sakwa 1997).

The Russian health care system has also undergone a series of sweeping changes since the end of 1991. During the years of the post-Soviet transition, health reformers across Russia have tried to devise strategies that would maintain the best of the old system – universal access – while introducing market based incentives for providers and consumers alike that would improve the quality of care (Twigg 2002). In the Soviet Union extreme emphasis was placed on the socialist-oriented priorities of access and equity, sometimes at the expense of quality and efficiency. Despite sophisticated centres of excellence in major cities, Soviet official medicine in rural areas was starved of resources (Davis 1989).

The process of privatisation of medicine in Russia started in 1985 when some medical institutions were put on a self-financing basis. The privatisation of state medicine,

however, was legally underwritten only in 1993, when the 41 Article of the Constitution of the Russian Federation gave the green light to all kinds of private initiative. The privatisation of medicine has been implemented to different degrees. The conditions of the accreditation of private practice and the attitudes of the regional elite towards the introduction of private practice varied from one region to another. As a result, the demopolisation process towards a mixed market in health care with private as well as state run services unfolded in various regions at a different pace. In 2003, the overall market of official private services was equal to 6 milliards of roubles, whereas the state allocations to medicine were equivalent to 31 milliards of roubles (Shevchenko 2002; Zavialova 2003). The head of the department of private medical insurance of the largest Russian insurance company 'Ingosstrach' Kopitaiko argues that private medicine currently comprises from 10 to 15% out of all health care in Russia (Kopitaiko 2003).

In the early 1990s, as part of the trend towards marketisation, there were also changes in the funding structure of the health system. Russia moved away from complete state budget financing of health care towards an employer-based national health insurance system with decision-making powers devolved to the regions and a system of contracting between the regions as funders and the medical institutions as providers (Field 1995). Employers, employees and municipal governments (on a capitation basis) make compulsory contributions into one of 89 regional health insurance funds. These insurance funds, which are autonomous non-profit organisations, act as intermediaries between those insured and providers. They enter into contractual agreements with provider agencies so that there is an element of purchaser-provider split similar to that introduced as part of the 1990 health reforms in the UK (Allsop *et al.* 1999). Insurance funds are supposed to guarantee the rights of patients and quality control, and may be provided on a number of different bases. There may be cost per case contracts for hospitals and capitation contracts for polyclinics.

The introduction of the compulsory insurance system was intended to overhaul socialised methods of health care financing and delivery and to replace them with a structure of competitive incentives to improve efficiency and the quality of care (Twigg 2002). The results, however, have so far not been encouraging because of the evident unwillingness on the part of health care organisations and the inability of many enterprises with low and negative profits to pay insurance premiums for their workers as



is prescribed by the law. All enterprises have been supposed to assign 3.6% of their income to these health insurance funds. Not surprisingly, implementation problems such as raising contributions and maintaining the flow of funds have been reported (Rozenfeld 1996; Bobak *et al.* 1998). Moreover, the current level of employer payroll tax for compulsory medical insurance appeared to be too low to satisfy the needs of the health care sector.

Indeed the manner of obtaining resources has changed, but not the principles of medical management. The whole reform process, for the moment, is taking place in the financial field only; but the very idea of medical insurance concerns many other issues, such as the organisation, management, and delivery of health care, and not only the payment mode (Rozenfeld 1996). The chosen model of the compulsory insurance system accepted recently in Russia essentially serves to simply transfer money from the insurance funds, through insurance companies, and ultimately to the medical facilities without regard to the actual volume of services rendered. The compulsory insurance system does not function as a true insurance system because market conditions are still absent. In this case, no real incentives are present, and despite the fact that the insurance law is couched in terms of free choice for patients of both hospitals and physicians, in practice there is still little choice (Allsop *et al.* 1999). As a consequence of the chronically underfunded health care, the tendency towards centralised control has been preserved in Russia. There are still strong elements of price fixing and methods of payment which gives little incentive to use health facilities more efficiently (Field 1995). However, the financing reforms have increased the differentiation between medical institutions in terms of the forms of financing which in turn have created a variety of employment opportunities for medical practitioners, as is discussed below.

### **1.1. Privatisation of medicine: differences between Moscow and the regions**

The health care reforms have resulted in the differentiation of the medical institutions into three distinct categories: (1) state-owned institutions financed by the federal and municipal budgets and by the health insurance funds; (2) state-owned institutions with mixed financing partly covered by the state and the insurance fund and partly earned by doctors in the self-financing departments; (3) private medical institutions which are present in the market in the forms of joint-stock companies, foreign companies, joint venture, and mixed ownership.

The forthcoming health care reforms plan to preserve only state-owned institutions with *mixed* financing and private medical institutions. In 2004, a newly elected Minister of Health and Social Development Zurabov proclaimed that since 2005, the state medical authorities plan to get rid of all the state-owned institutions which do not have self-financing departments (Mustaphina 2004). As a result, half of the medical practitioners employed in the state sector will have to be dismissed. State medical authorities presume that this will increase the efficiency of work, and the income, of those doctors who retain their posts in the state sector. It is worth noting that the prices for most types of medical services used in self-financing departments will still have to be negotiated with the Ministry of Health. The declaration of further reforms has provoked complaints on the part of medical practitioners, who have argued that it will destroy the state health care sector (Mustaphina 2004). These apprehensions seem to be well-grounded. The research undertaken for the thesis showed that the viability of self-financing departments was not high enough and differed greatly among the regions.

The likely desire of the population for fee-for-services should not be overestimated. The questionnaire showed that in Moscow on average, about 25-40% of the budget of the medical institutions came from self-financing departments, whereas in Komi and Kirov regions it was less than 10%. This suggests that demand may be generally limited to the simplest and cheapest services for fees and to those still left free of charge. The demand for high quality services is not yet formulated, because family budgets are already under stress from other financial pressures. However, Moscow doctors were in an advantageous position in relation to the viability of self-financing departments. The reason for this was the level of demand from patients who were able to pay for expensive services that were of better quality or beyond the scope of those rendered free-of-charge. In 2002, the average income of Muscovites, for example, was more than twice as high as the average income in Kirov (State Statistical Department 2002). In Moscow, the average income was 7.293 roubles (~235US\$) and in Kirov – 3.202 roubles (~103US\$).

In Moscow, the profits of self-financing departments and better state financing have resulted in improvements in health facilities, non-existent in the regions. The questionnaire findings showed that it was only in Moscow that respondents thought that changes for the better had occurred since the medical reforms (as shown in Table 5.1 below). Almost half of the Moscow medical practitioners reported that there had been



improvements in the state of affairs of their medical institutions. In contrast, medical practitioners from Komi and Kirov regions said that there had been no changes for the better since the medical reforms. From their point of view, technical equipment and building maintenance had become dramatically worse and so had the supply of medical and routine goods. Overall, only one tenth of the provincial respondents said that the conditions of work had improved; while almost a quarter of those in Moscow said there had been improvements in working conditions. For the majority of provincial medical practitioners, conditions had stayed the same or even deteriorated.

**Table 5.1: Views on changes in the state of affairs in the medical institutions**

		Regions (%)		
		Moscow	Komi	Kirov
Technical equipment supply	Changed for the worse	18	50	41
	Stayed the same	24	12	17
	Changed for the better	44	14	28
Maintenance of technical equipment	Changed for the worse	22	54	52
	Stayed the same	21	14	20
	Changed for the better	42	7	14
Medical and routine supplies	Changed for the worse	23	44	52
	Stayed the same	22	17	17
	Changed for the better	41	11	16
Working conditions	Changed for the worse	22	35	35
	Stayed the same	45	38	45
	Changed for the better	22	9	10

In this Table more than one category could apply.

There was also an observable distinction between the profitability of the self-financing departments of medical institutions within the same region. The status of the outpatient and in-patient medical institutions and their opportunities for raising income differed greatly. The questionnaire research showed that the hospitals in all the regions under study were better equipped and had a wider spectrum of medical services on a fee basis than polyclinics. This was except for some polyclinics with advanced technology and/or where they rendered services for ‘eligibles’ of different kinds such as ministry workers and leading military men. The interviews with head doctors showed that outpatient

medical institutions also faced a problem of the lack of well-qualified doctors: a large proportion of the qualified specialists had left primary care for the hospitals and departmental polyclinics. As a consequence, the labour force of the latter had improved at the expense of the primary care sector. Moreover, interviewees mentioned that new recruits, the graduates of the medical faculties, tend to choose a career within a medical specialism rather than general practice which gives less opportunity for private income. In summary, changes in health care have been so major that it can be expected that they would take years to implement. And a great deal of the success of health care reforms will depend on the social attitudes of medical practitioners and their strategies for adaptation. These are considered more fully below.

## **1.2. Strategies for adaptation: diversity of employment strategies**

The questionnaire research showed that extra earnings from professional practice of medical practitioners were almost as important for them as their wages. In general, medical practitioners rated the importance of their wages at a rather high level: 4.5 on average on the scale from 1 to 5. The respondents also gave the extra earnings from professional practice high marks: 3.7 on average on the same scale. These data and the interviews with head doctors in Komi region enabled the identification of two main strategies for adaptation of medical practitioners. They can be roughly subdivided into two categories: (1) secondary employment within the state sector and (2) formal and informal, unofficial private practice. In the Soviet period, as a rule only doctors in managerial positions could draw two salaries, one as a doctor and one as a manager (Schlachter 1998). Currently, there have been numerous cases of secondary employment within the same medical institution such as extra work for two wage-rates; part-time work in self-financing departments or holding posts in different medical institutions simultaneously.

In interviews, head doctors said that secondary employment within the formal state sphere of employment had become a mass phenomenon, as a means of survival for medical practitioners with a low salary. However, as the questionnaire research showed, employment in self-financing departments of medical institutions did not necessarily guarantee a medical practitioner upward mobility in terms of income. As has already been mentioned, the profitability of the self-financing departments differed greatly.



Moreover, it was the medical administrators (head doctors) who decided what proportion of the earnings from private health care would be spent on salaries and bonuses to staff. In some medical institutions, for example in Komi region, medical practitioners received less than 10% from their income earned in a self-financing department.

As far as private practice was concerned, most doctors involved in it did not leave their current post in a state medical institution when they provided services on a fee basis. Zaslavskaya argued that combining private business with a job in the state sector has been a specific feature of post-socialist countries, where this is called ‘part-time business’ (Zaslavskaya 1995). Russian private medical practitioners both self-employed and part-time employees at private medical centres fitted well into this category. As the majority of the respondents who had private practice also held a secondary employment within the state health care sector. In the questionnaire, 65% of private medical practitioners said that extra earnings from professional practice, other than private practice, were important for them. As the interviews with head doctors showed, these medical practitioners were often involved in private practice as their second jobs, and this tended to be more on a casual and episodic basis. However, one of the most interesting results of the study was the finding that the majority of all respondents would prefer to work in the private sector, were they given a choice. The data on preferences as regards to the place of employment of the medical practitioners are shown in Table 5.2 below:

**Table 5.2: Given the choice, where respondents would prefer to work**

Type of medical institution	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
State medical institution	16	17	7	14
State institution with fees-for-service	28	30	33	30
Private institution	44	37	37	40
DK	12	16	23	16
Total	100	100	100	100

Thus, the number of medical practitioners who were not happy with their working conditions in the state sector was high. The most discontented group was the

Muscovites where 44% would have left the state sector<sup>20</sup>; although the provincial doctors were also quite dissatisfied (37% would have left the state sector). So, if doctors in the labour market were guided only by their preferences, then employment in the state sector would have reduced by four times in Moscow and in Komi, and would have dropped by nine-fold in Kirov. As the percentage of private practice in the regions under study was unknown, with the exception of Komi region, it was hard to estimate albeit hypothetically the possible growth of the private sector there. In Komi, private services comprised 3% of the health care sector (Luksha 1999). Thus, the scope of private practice would have grown there in approximately 12 times, were the market conditions mature and the medical practitioners ready.

The declared desires to leave the state sector in favour of private practice did not correspond to the behaviour of medical practitioners in the sphere of employment. All in all, only 25% of the respondents said they were involved in the search for a new employment (see Table 5.3 below). In the interviews, head doctors argued that a limited number of medical practitioners were inclined to leave the state sector and start a private practice of their own, as it was still considered quite risky and posed a number of problems. The interviewees said that the main reason for leaving the state sector was connected with dissatisfaction with wages, and it was not so much a search for the better future, as the necessity simply to survive. So, in the view of head doctors, labour mobility in the health sector had, to a great extent, been forced mobility in a period of crisis.

**Table 5.3: Medical practitioners' search for employment in the health services market**

	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
Searching for employment	24	22	28	25
Not searching for employment	76	78	72	75
Total	100	100	100	100

There were differences in the labour market behaviour between the medical practitioners of a different age, gender and specialty. Men were slightly more active than women: 29% of men and 24% of women said they had searched for a new post.

<sup>20</sup> This may also indicate that Moscow medical practitioners have more opportunities for employment in the private sector.



The most active in searching for work were those under the age of thirty (37%) and between 31 and 45 (29%). The most passive group were those over 45 (among them just 16% searched for a new job) and the pensioners over 55 (of whom only 8% had looked for another job). In summary, privatisation opened up diverse opportunities for the employment of medical practitioners. However, as the research showed, despite increased opportunities for private practice, most medical practitioners were not ready to leave the state sector, because of the attachment to the state socialised medicine and the prejudice against some health care reforms. These social attitudes of medical practitioners are considered in the following section.

## **2. The social attitudes of professionals towards the reforms in health care**

### **2.1. Attitudes towards the medical insurance system**

The pilot interview research showed that the functioning of the medical insurance system was not transparent for medical practitioners. Some of them even did not realise the difference between the compulsory and private insurance system. Indeed, at the time of research, private medical insurance had been introduced only in Moscow; it did not function in Komi and Kirov regions. However, some rank-and-file medical practitioners (about 40% in Kirov and about 62% in Komi region) thought that it had functioned in their regions as well. In general, the money that came through the insurance system and through the state many rank-and-file medical practitioners considered to be institutional 'budget money'. The health insurance fund was 'inscribed' into the state system. So, the doctors thought that the fund of health insurance shared with the Ministry of Health the responsibility for the low wages, unsatisfying working conditions and life chances. The attitudes towards compulsory medical insurance system are summarised in Table 5.4 below:

**Table 5.4: Changes in medical institution after the introduction of compulsory medical insurance**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
Technical equipment supply	Changed for the better	22	9	20	18
	Stayed the same	46	30	60	42
	Changed for the worse	15	38	3	24
	DK	17	23	18	16
Medical and routine supplies	Changed for the better	24	6	15	17
	Stayed the same	48	32	71	50
	Changed for the worse	12	41	5	17
	DK	17	22	10	16
The level of doctors' wages	Changed for the better	20	9	15	16
	Stayed the same	47	30	71	49
	Changed for the worse	18	41	10	20
	DK	16	20	10	15
The quality of patient care	Changed for the better	10	7	12	10
	Stayed the same	71	58	74	69
	Changed for the worse	3	13	1	5
	DK	15	21	12	16

As it seen from Table 5.4, in general medical practitioners had mixed views on whether the introduction of compulsory medical insurance had had an impact on the state of affairs in their medical institutions. More than half said that compulsory medical insurance had either negatively affected or did not change at all the following things: the supply of technical equipment (64%); medical and routine supplies (67%); the level of doctors' wages (69%); and the quality of patient care (74%).

**2.2. Attitudes towards the privatisation of medicine**

Despite the fact that more than a third of all the respondents said that they would prefer to work in the private sector, were they given a choice, there was a widespread sense that some characteristics of the system of state socialised medicine must be preserved.



The majority (60%) of doctors said that they supported a partial privatisation; 23% of the respondents did not support privatisation at all and just 15% supported the privatisation without reserve, even if there was some element of payment for health care. Overall 83% of doctors said that some groups in the population must be exempt from payment for health care. They gave priority to a service free at the point of access to handicapped, children, low-income families and medical practitioners themselves (see Table 5.5 below). The questionnaire findings showed that the value of altruism was widespread among medical practitioners. The interviews in Komi region showed that there were private practitioners who gave 30-50% discounts for pensioners, medical workers and other low income groups.

**Table 5.5: Population groups which it was felt should be exempt from paying**

	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
Handicapped people	76	84	82	79
Children	59	87	88	73
Low income families	65	64	49	61
Medical workers	50	57	77	58
Large families (three children and more)	43	47	40	43
People with a chronic disease	44	36	21	36
Pensioners	44	36	21	36
Others	6	4	3	5
DK	3	2	2	2

The pilot research had also indicated that doctors also thought that certain areas of practice, as well as certain groups in the population, should be exempt from payment. In the interviews, head doctors argued that some services should be free at the point of use for all the population. In the questionnaire survey there was an attempt to estimate which medical services might carry charges and which should stay within the free-of-charge state services. It was found that medical practitioners did not reject the idea of introduction of the fees-for-service within the state sector. However, their view was that fees for services should first be introduced for areas of health care not directly connected with the life and immediate well-being of the patient (see Table 5.6 below). Respondents to the questionnaire mentioned that payments could be made for those services that had to do with the non-medical side of the things such as better quality wards and separate wards for inpatients (78%). Moreover, quite a large group of

medical practitioners argued that cosmetic surgery (75%) and alternative medicine (52%) should carry charges, whereas less than half of the respondents supported the idea of charges for the services of medical specialists (44%), dentists (42%) and general practitioners (21%). About one third of doctors agreed that advanced diagnostic tests (37%), physiotherapy (26%) and services for inpatients such as board and lodging (29%) could be offered on a fee-for-service base in a state medical institution.

**Table 5.6: Medical services which it was believed should be provided on a fee-for-service basis**

Type of services	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
Medical specialists' consultations	41	46	48	44
General practitioners' consultations	23	16	22	21
Alternative practitioners' consultations	45	58	59	52
Services for inpatients (board and lodging)	31	22	33	29
Laboratory tests	35	32	44	36
Additional services (separate words for patients, etc.)	75	75	89	78
Ward (rooms') lease	35	41	43	38
Advanced diagnostic tests (e.g. computer-assisted, etc.)	30	38	48	37
Stomatology	42	42	43	42
Cosmetic surgery	73	76	77	75
Physiotherapy and other type of treatment	25	23	31	26

Thus, a larger proportion of medical practitioners supported charges for the services of medical specialists as compared to general practitioners. Head doctors interviewed after the questionnaire research, commented on the issue of different attitudes towards privatisation of medical specialism and generalism. They presumed that medical practitioners answering to this question quite likely took into consideration the existing state of things, as there was more demand for consultations with medical specialists than for the consultations with general practitioners. For example, the medical specialists from Komi region provided services for a fee four times more often than the general practitioners did. In Kirov – three times more often, and in Moscow – one and a half times more often. Despite the wide spectrum of private services at the medical



institutions under study, some medical practitioners were still reluctant to support privatisation and were apprehensive of the reforms.

### **2.3 The attachment of professionals to the state sector and the notion of state socialised medicine**

The interviews showed that many medical practitioners were not ready for the market and privatisation as they remained attached to the notion of socialised medicine, which guaranteed certain social benefits to medical practitioners themselves and to their patients. Most doctors interviewed did not give up their job at a state medical institution, as this might lead to the loss of their social and welfare benefits. Another reason was the importance of retaining registration as an employee in a state medical institution in order to maintain their work record and to qualify for a pension. In the past, registration also provided access to a further range of social benefits such as free or subsidised housing. Nowadays, although this benefit had largely gone as housing construction for medical institutions had been cut back, some medical practitioners said that there was still a chance that new apartments could be sold to medical practitioners at reduced prices.

Also important was the finding that the Soviet work ethic, particularly among older people, still persisted. The interviews with head doctors brought out a few important social attitudes and stereotypes that remained from the past:

- A priority was to remain employed in a permanent place of work, in which the person worked for many years. There was a high degree of attachment to the labour collective.
- The ideal of Soviet socialised medicine was maintained although there was also partial support of the privatisation process. This finding corresponds to other research findings (see, amongst others, Twigg 2002)

Soviet ethics involved not only a commitment to the profession, but also an attachment to the labour collective as what many workers referred to as their second home. This corresponds to Clark's (2002) research showing that in Russia, the Soviet sense of the labour collective, shorn of its Communist rhetoric, continued. In the questionnaire survey, it was found that doctors considered their colleagues to be the most significant reference group, whose opinion they valued. 81% of the respondents turned to their

colleagues for help in the cases when the ethical dilemmas arose in their practice (see Table 5.7 below). Colleagues too came first (37%) in the list of those who provided protection for doctors, leaving behind the medical association and trade unions. Moreover, 74% of doctors shared their dissatisfaction with the quality of medical care primarily with their colleagues. Medical practitioners did not attach the same degree of trust to medical administrators as well as other professional and justice bodies. Moreover, even in the case where a mistake by medical practitioners had resulted in a death, 40% of respondents said they would prefer to see their colleagues dealing with this.

**Table 5.7: To whom medical practitioners refer**

	Reference groups (%)				
	Colleagues	Administra tion of medical institution	Family	Trade union	Medical association
Discussions of ethical dilemmas	81	21	25	2	2
Dealing with medical mistakes	40	63	N/a	N/a	14
Dissatisfaction with the quality of medical care	74	31	18	2	1
Protection for doctors	37	36	N/a	10	6

\*N/a – not applicable

Under economic and social conditions where the majority of the population, could not afford private medical services and medicaments, private practice did not fit well with professional ideals and values. In the interviews, some doctors shared with us their concern that their active involvement in private practice could also lead to a loss of respect among their colleagues. Private practitioners were sometimes treated by their former colleagues and patients as people who had sacrificed professional and social values for private gain. Most doctors referred to their private practice as ‘earning on the side’ or as ‘earning a little extra’, even though their income from private practice might become the main source of income.

To summarise, the majority of medical practitioners (83%) said that they supported a *partial* privatisation or did not support privatisation at all. Although medical practitioners were frustrated and apprehensive about market-oriented reforms in the



abstract, they were willing to overcome those apprehensions in favour of opportunities to earn more money. Concerns expressed by these respondents about the privatisation of health care could indicate philosophical opposition to the notion of privatisation in general. Or it could simply reveal scepticism about how market reforms had actually operated, or might operate in the future, in Russia. As Twigg rightly argues, concrete observations of Russian citizens about the unpleasant results of market forces in their daily lives could easily give them cause to hesitate in supporting a market for medical services in practice, even if in principle they might be inclined to back the concept of market-oriented reform (Twigg 2002).

### **3. Dynamics of the social standing of orthodox medical practitioners during the reforms**

Before looking at the impact of health care reforms, it is first useful to reiterate that the system of health care that existed in the Soviet Union immediately prior the 1992 reforms was highly centralised (see the details in Chapter III). Until the end of the 1980s, health services were funded from taxation for service provided free at the point of use (see, amongst others, Allsop *et al.* 1999). The Ministry of Health at the centre dictated policy and determined resource allocation to the regions and districts in the Soviet Union (Davis 1989). This included setting prices for medicines and equipment and the salaries of health personnel. Capital expenditure was closely controlled, as was the training of health practitioners. Thus, in the former Soviet Union, medical practitioners could not operate as independent professionals. Soviet doctors differed from their Western colleagues in that they did not have an exclusive jurisdiction in a particular division of labour controlled by occupational negotiation. They did not either have a sheltered position in both external and internal labour markets based on qualifying credentials created by the professional association.

In 1991, organisational changes in health care and opportunities for private practice have possibly created the conditions for change in the social standing of Russian doctors. And in the questionnaire research, there was an attempt to analyse whether it might be that the medical profession had acquired greater autonomy and self-regulatory powers. The research investigated this by assessing the scope for participation for rank-and-file doctors, in or through medical administration; in, or through, trade union

activity; and lastly through membership of medical associations. As was discussed in chapter I, within the context of Russia, professionalisation could be analysed from a neo-Weberian perspective. Thus, an attempt was made to estimate whether members of a professional group pushed for enhancement of the scope of power, and the gaining economic or cultural resources in the market place or for influence within the state sector, in order to achieve a legally underwritten professional monopoly. The extent of power, financial and cultural resources of medical practitioners was given a special attention in the questionnaire research, the findings of which are presented further below.

### **3.1. Power resources of medical practitioners**

The power resources of doctors were central to the analysis. In the Anglo-American model, power resources derive from the exercise of professional autonomy in a number of spheres (Freidson 2001). As was discussed in Chapter I, the scope of power resources determines the opportunities of a professional group in different social dimensions such as income, prestige, and interesting work. The resources of power used to analyse the INTAS data are summarised as follows: (1) the relative autonomy in making professional decisions, particularly in the sphere of diagnostics and medical treatment; (2) the influence on the scope of a professional remuneration; (3) the professional control over group entry: social closure in the market and in the system of education; (4) the professional control over group exit via the sanction mechanism; (5) the existence of a strong professional organisation as in medical associations or trade unions<sup>21</sup>. Other aspects of power analysed were the ability to determine conditions of work such as work plans and the pace of work. Before considering these aspects of professional practice, legal health care regulations need to be explained.

According to official regulations, the medical management system in health care continues to endorse the central authority of the Minister of Health and this is legally underwritten (State Duma 1997). The Decree of the State Duma proclaimed that 'all regulations and rules of the Minister of Health and all instructions of the Ministry of

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<sup>21</sup> The membership of Russian medical practitioners in trade unions is still larger than membership in medical associations. In our sample, more than half of all surveyed were members of trade unions, whereas only a fifth of them were members of medical associations.



Health on the questions of diagnostics, treatment and prevention of ill-health... are compulsory for all enterprises, institutions, organisations and associations regardless of their departmental subordination and forms of ownership'. Moreover, the Minister of Health can appoint to a post and discharge from it all Ministry of Health employees and head doctors of the state health care institutions (State Duma 1997).

Thus, officially, the state does not allow the medical profession to govern itself. Those who occupy positions at the top of the state bureaucratic hierarchy, whether medically qualified or not, determine the scope of regulation of those professionals who occupy lower level positions. Thus the medical administration in lower level institutions can do little without Ministry of Health approval, nor behave in a way contrary to instructions from above. In interview, the majority of head doctors agreed that the Ministry of Health governs the profession through a broad web of regulation. The central mechanism is through the allocation of funding that determines the institutional budget. However, regulation is very detailed and there is very little discretion at the lower level. Even the prices for fee-for-services in self-financing departments are predetermined by the Ministry of Health.

### **3.1.1. Power resources of rank-and-file doctors, trade unions and medical administrators**

In the questionnaire survey, an attempt was made to assess what decision-making powers doctors felt that they had within their institutions. Overall, about two thirds (63%) of doctors said that their inability to influence decision-making in medicine worried them. However, there were regional differences. Only just over half (55%) of Moscow medical practitioners were worried by their lack of influence on decision making in medicine, while over two-thirds of doctors within Komi region (70%) and Kirov (71%) were concerned about their lack of influence. Table 5.8 below shows the data on the degree of influence that different groups – medical administrators, trade unions and rank-and-file doctors – could exercise over different forms of activity<sup>22</sup>.

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<sup>22</sup> The pilot research showed that medical associations did not interfere with the state of affairs in medical institutions.

**Table 5.8: Medical administration, trade union and rank-and-file doctors' influence**

	Medical Administrators	Trade Union	Rank-and-file doctors
Admittance of new doctors	4.4	1.3	1.5
Dismissal of doctors	4.1	1.4	1.4
Drawing up work plans	3.8	1.3	2.3
Work tempo	3.5	1.3	2.6
Wage levels	3.6	1.3	1.5
Bonuses/allowance payments	3.9	1.5	1.4
Medical institution funds: profit, credit, etc.	3.8	1.2	1.3
Control over doctors' work quality	4.0	1.3	1.9
Changes in working conditions	3.4	1.4	1.7

This Table is based on the following scale: 5 – very great influence, 4 – great, 3 – medium, 2 – little, 1 – no influence, centred on the mean scores from Moscow, Komi and Kirov regions

As Table 5.8 above shows, rank-and-file medical practitioners appear to have had almost no influence over (1) the admittance, and dismissal, of doctors and (2) remuneration, such as wage levels, bonuses/allowance payments and medical institution funds. And they could not change their working conditions and control the quality of work of their colleagues. Rank-and-file medical practitioners had from little to medium autonomy in drawing up work plans and setting work pace. Decision-making in the sphere of diagnostics and medical treatment was curbed particularly in primary care, which was reflected in the systems for payment there. Primary health doctors were paid by the number of patient attendances at a level determined by the guidelines of the Ministry of Health. As the interviews showed, many doctors were discontented with this form of piece-rate pay. The prescribed number of visits often did not correspond with the demand of patients for care or with the capacity of professionals to provide health care. Ministry of Health guidelines, however, were a form of rationing system and difficult to alter.

Rank-and-file doctors believed they had next to no influence on their wage level and bonus payments, although the majority of them said they were dissatisfied with their low wages (Moscow 70%; Komi 88%, Kirov 98%). It was expected that trade unions would feel that they had a greater influence on the financial issues, as these organisations were initially formed with the objective of improving salaries and working conditions. However, as Table 5.8 above indicates, trade unions were no longer able to exercise influence in this and other areas. According to the mean scores



presented in Table 5.8, trade unions were even less influential than rank-and-file doctors. They had little to no influence on the issues of control over entry and exit into the profession: they did not influence the remuneration and had no impact on the changes of working conditions of doctors and the quality control.

Although, in the interviews, head doctors said that trade unions varied in their ability to exercise influence. Some remained quite strong. There had been a few cases where trade union leaders had brought an action against a medical institution for failing to pay back-wages. Other trade unions tried to influence the policy of the Ministry of Health. For example, in relation to issues affecting working conditions and life style, some trade unions made recommendations, lodged complaints, or demanded solutions. Some medical trade unions tried to improve the low standing of medical practitioners. However, the questionnaire results showed that influential trade unions were perceived to be an exception.

Overall, the questionnaire respondents said that the power of the medical administrators surpassed that of the medical associations and trade unions. However, many medical administrators did not see themselves as being ‘very influential’. They said that budget constraints and tight Ministry of Health’ regulations limited the scope of their decision-making powers. For example, many head doctors said that they were not permitted to lease excess physical space in their facilities. They were also clearly frustrated with the administrative limitations placed on their flexibility in spending the resources the government budget allocates to their facilities, a system that prohibited them from shifting money between specifically delineated line items: wages, medications, capital repair, utilities. They argued that they should enjoy more flexibility in spending budget money. The lack of strong power resources of head doctors was evident in raising medical institution funds, wage levels and changes in working conditions predetermined by the guidelines of the Ministry of Health and work tempo.

### **3.1.2. Power resources of medical associations**

The research showed that medical practitioners did not consider professional medical associations to be strong either. As it is shown in Table 5.9 below, only 6% of medical practitioners turned for support to medical associations. The majority of them turned to

their colleagues (37%); medical administrators (36%) and trade unions (10%). whereas 33% of medical practitioners said that there was no protection for doctors at all.

**Table 5.9: Who doctors turned to for support and protection**

Reference groups	Frequency	Percentage
Colleagues	218	37
Medical institution administration	213	36
There is no protection for doctors	192	33
Trade Union	59	10
Medical Association	37	6
Ministry of Health	28	5
Justice bodies	15	3
International organisations	7	1
Other	16	3
Total	785	—

In this Table more than one category could apply

The interview research indicated that medical associations most often acted as scientific societies where doctors of the same specialty shared their work experiences and discussed difficult medical cases. Some members of the medical associations participated in the state committees that certified private practitioners, and those that determined the ranking category of doctors. Russian doctors are given a category according to their professional level. For example, the category of ‘outstanding merit’ is awarded to a doctor with the length of service longer than 10 years and extensive experience within a particular specialty. The first category and the second category relates to doctors with the length of service equivalent to 5 years and 7 years with the corresponding experience in a specialty. Representatives of medical associations were often engaged in the certification of the ranking category. Moreover, medical associations might also offer financial or legal assistance to the association members in malpractice cases.

In interviews, head doctors explained the absence of strong medical associations as a consequence of a lack of ambition on the part of rank-and-file doctors. They suggested that these doctors did not think in terms of upward social mobility for themselves or their group. When confronted with infringements on the rights of medical practitioners, most of them remained passive and did not try to defend their rights because they did not believe in the eventual success of their ‘struggle for justice’ or feared that this struggle would bring more losses than benefits. They were more likely to look to private



practice and working extra hours to enhance income, rather than seeking advancement through professional channels or additional qualifications. Other head doctors stated that most Russian doctors lacked the funding to finance the work of associations. As a result, many professional associations drew on contributions granted by the Ministry of Health. They had limited opportunities to hire personnel and, therefore, they survived due to the commitment of dedicated professionals.

Moreover, some specific features of the historical development of Russian medical profession restrained the development of medical professional associations. Most doctors have accepted the reality of a dominant state bureaucracy that did not only control access to medical posts, but also determined exit from them. It could apply sanctions and dismiss a doctor for poor practice. Therefore, tight state regulations still deprived medical professionals of the ability to control the quality of the work of their colleagues, their training and accreditation. Doctors were subordinated to state officials and academics. The documentary data showed that some Ministry of Health officials were themselves well-educated professionals. However, their qualifications were not necessarily equivalent to those of the top-quality medical specialists. For example, in 2001, twenty-three doctors were on the staff in the Ministry of Health of Komi region, and only five of them had the prime category ranking, while others had no category at all<sup>23</sup> (Bureau of Medical Statistics 2001). In summary, medical professional associations lacked influence on the life of rank-and-file doctors. However, as it will be discussed below some elite professionals and major professional associations attempted to cooperate with the state in different spheres from the management of the health care system to the creation of new professional ethical principles. And some professional associations even saw professionalisation as one of their primary goals.

### **3.1.3. Power resources of private practitioners**

Those who undertook private practice did not see themselves as gaining in terms of increased autonomy either, as is seen in Table 5.10. Doctors in private practice still came under the supervision of the medical authorities in the Ministry of Health who controlled the standards of work and closely supervised the financial aspects of private practice.

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<sup>23</sup> This means that they had less than five years of medical practice.

**Table 5.10: The influence of rank-and-file private and state medical practitioners on the professional matters**

	State	State with fee-for- services	Private
Admittance of new doctors	1.5	1.4	1.6
Dismissal of doctors	1.4	1.4	1.4
Drawing up work plans	2.2	2.3	2.5
Work tempo	2.6	2.7	2.9
Wage levels	1.4	1.3	1.9
Bonuses/allowance payments	1.4	1.3	1.7
Medical institution funds: profit, credit, etc.	1.2	1.4	1.7
Control over doctors' work quality	1.9	2.0	2.0
Changes in working conditions	1.7	1.6	2.1

This Table is based on the following scale: 5 – very great influence, 4 – great, 3 – medium, 2 – little, 1 – no influence, centred on the mean scores from Moscow, Komi and Kirov regions.

Private practice still did not have a well-defined economic and political status. However, private practitioners had acquired greater control over the content of their work and their working conditions. They were also better placed to control the tempo of their work. In contrast to state employees, their income had increased.

**3.2. Financial resources of medical practitioners**

The majority of medical practitioners said that their income had dropped sharply since the beginning of the reforms. In 1999, for example, real disposable personal income of 60% of Russian medical practitioners was equal or lower the subsistence wage (Demoscope Weekly 2001). In 2003, the average income of medical practitioners was 3.707 roubles which was just half as much again as the subsistence wage. In the same year, the arrears of wages were more than 565 million roubles (Mustaphina 2004). It is a disturbing commentary on the reforms that 82% of medical practitioners said that they were dissatisfied with their economic position and not confident about their future.

Even more important was the widespread sense that the system of remuneration was unfair – that it did not provide real opportunities and did not reward effort. In the Komi interviews, head doctors said that the current system of physician remuneration, which paid salaries solely according to years in service and level of specialty, should be abolished in favour of a market-based payment system. Perhaps not surprisingly, they believed that the needs of doctors were still being ignored, and indeed, in certain



respects that the social and financial benefits of medical work had decreased. Respondents estimated their own financial standing as ‘quite low’. Table 5.11 below shows that although most respondents had enough money for food and clothes, there were insufficient funds for other necessities:

**Table 5.11: Medical practitioners’ estimate of the current financial situation of themselves and their families**

	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
We live from hand to mouth	1	9	14	6
We have enough money for food. We cannot afford new clothes	16	54	51	34
We have enough money for food and clothes. We cannot afford expensive household things (TV set, fridge, etc.)	48	29	31	39
We can buy most expensive household things, but we cannot afford a new car or a dacha	32	7	4	19
We do not deprive ourselves of anything	4	1	0	2
Total	100	100	100	100

The financial position of Moscow doctors was better than that of provincial doctors. However, there was no consensus about whether wage levels had fallen, risen or stayed the same since the health reforms. One third thought that their wages had risen since the reforms. Another third believed that they had fallen, the remainder thought that they had stayed the same. The reason for this lack of consensus among Moscow doctors may be that the range of potential income sources had increased. In the provinces in contrast the possibilities for private practice had not expanded greatly: only 12% of Kirov respondents and 19% of Komi medical practitioners mentioned a growth in income.

After the questionnaire research, the author singled out the group of the respondents who said that they had improved their economic position since the beginning of the reforms to identify the characteristics of this group. It was found out that there was no correlation between the pattern of income growth and the personal variables of the respondents defined by skill, specialty, age and gender differences. Irrespective of their personal characteristics, those doctors who had improved their material situation were more market oriented: either had secondary employment or provided services privately in an official or unofficial way. As it is shown in Table 5.12 below, for many respondents extra earnings from professional practice were as important as their wages.

**Table 5.12: Importance of income sources for state employed doctors**

	Moscow	Komi	Kirov	Total
Doctor's wages	4.4	4.7	4.7	4.5
Other household wages	4.3	4.4	4.6	4.4
Doctor's extra earnings from professional practice	3.5	3.8	4.1	3.7
Doctors earnings from other sources	1.8	2.7	3.1	2.3
Social security benefits	2.5	3.0	2.9	2.7
Rent from housing	1.3	1.5	1.6	1.4
Interest from investments/ savings	1.6	2.0	1.7	1.7
Savings	2.0	2.5	2.2	2.1
Help from relatives and friends	1.8	2.8	3.2	2.2
Other	1.2	2.3	3.4	1.8

This Table is based on the following scale: 5 – very important, 4 – important, 3 – somewhat important, 2 – hardly ever important, 1 – unimportant, centred on the mean scores from Moscow, Komi and Kirov regions.

Overall, 55% of Muscovites, 52% of Komi doctors and 65% of Kirov doctors said that extra earnings from professional practice were important or very important for them. And the research showed that extra income from professional practice was equally important for both state employees and private practitioners. 55% respondents of the state sector, 59% respondents of the state with fees-for-service and 65% of the private sector stressed the importance of the extra income, which was earned as overtime work or in secondary employment. These findings show the existence of multi-faceted strategies for adaptation which doctors used to cope with the decline of the state financing of the health sector and unofficial payments was one of these.

### **3.2.1. Unofficial payments**

In the Russian press, estimates of the percentage of health care that is delivered illegally have varied widely, with Gerasimenko, then Chair of the State Duma's Committee on Health Protection, giving a figure as high as 40% (Shishkin 2003: 17). The questionnaire research supported the hypothesis that taking patients on an informal and unofficial basis for direct payment has become one of the major strategies for survival of medical practitioners. A block of sensitive questions that dealt with the issue of 'unofficial' payments for the services was included into the questionnaire. The views of doctors of the frequency of offers 'on the side' by patients is summarised in Table 5.13 below:



**Table 5.13: Frequency of offers of additional remuneration/gifts**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
How often patients offer additional remuneration/gifts to their doctors	Never	4	6	2	4
	Rarely	25	55	49	38
	Sometimes	38	27	33	34
	Often	19	3	11	13
	Very often	5	0	1	3
	DK	9	10	5	9
	Total	100	100	100	100

With such sensitive questions it cannot be assumed that medical practitioners were absolutely sincere in answering them. Doctors may find such questions intrusive and challenging their personal values, which could affect the response. Nevertheless, the general tendency in behaviour patterns was quite distinct. In the Soviet period, thanking doctors with presents, such as chocolates, flowers and alcohol was a common practice. Nowadays, as it is shown in Table 5.13 above, the messages of appreciation have turned into a tradition: just 4% of the respondents said that doctors were never offered ‘unofficial’ remuneration/gifts. Over one third (34%) of the respondents said that doctors were offered additional remuneration/gifts from time to time.

Nowadays the range of offers has widened; a quarter of state medical practitioners confessed that their colleagues had been offered money. Compared to the provinces, in Moscow a larger proportion of doctors were offered money, gifts and services as it is shown in the following Table 5.14:

**Table 5.14: Commonly offered remuneration/gifts**

		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
Remuneration, gifts that patients commonly offer to the doctors for their treatment	Flowers, spirits, chocolates	81	95	94	87
	Gifts	30	12	15	22
	Money	35	13	17	25
	Services	16	21	31	21
	Other	0	0	2	1
	Nothing	6	3	2	5

In this Table more than one category could apply

To find out the views of medical practitioners on unofficial remuneration, respondents were asked to choose one statement out of three and to give reasons for the answer. The

majority of the respondents (34%) chose the answer that doctors in the state medical institutions should *sometimes* get additional remuneration/gifts. The comments on the answer were the following: low wages, natural gratitude on the part of the patients and the incapability of doctors to maintain even minimum living standards. The research found out that 13% of doctors were active supporters of unofficial remuneration. They stated that patients should offer them a remuneration/gift in any case. Some respondents commented on the answer that they felt discriminated against by the low wage level and as a result took the remuneration/gifts for granted. At the same time, almost a quarter of respondents said that they would never accept remuneration/gifts from a patient. They referred to the ideal of professional altruism and the Hippocratic Oath as a reason for not wishing to accept money in return for medical treatment.

### **3.3. Cultural resources of medical practitioners**

The cultural resources of doctors were defined as those that derived from the specialist cognitive knowledge base of medicine (Bourdieu 1990). As was discussed in Chapter I, in the Anglo-American sociology of professions, 'professional expertise' and 'the professional ideology of altruism' are seen as important professional characteristics (Abbott 1988; Cant and Sharma 1996a). Public acceptance of professional advice was also seen as crucial in determining whether an occupation can be called a profession. In the questionnaire, an attempt was made to find out whether Russian doctors believed that their knowledge was valued and whether it was a source of their respectability. The professional ideology of altruism that asserts a greater commitment to 'doing good work' than to economic gain, and to quality rather than efficiency was taken to be a significant professional characteristic (Freidson 2001). In the questionnaire, Russian doctors were asked about the issues of the value of professional expertise and professional altruism.

#### **3.3.1. The value of professional expertise**

An interesting finding of the questionnaire research was the fact that medical practitioners did not directly connect the issue of the level of professional expertise and the quality of patient care with the worsened economic position. The questionnaire research picked up the discrepancy between the sense of unparalleled material shortcomings of medical practitioners and their rather positive estimations of the professional side of things. In general, medical practitioners rated the quality of clinical



work of their medical colleagues at a rather high level: 7.2 at the average on the scale from 1 to 10. The respondents also gave the quality of patient care high marks: 7.8 – on the same scale. The questions on the level of qualification, the quality of medical help and the opportunities to use professional knowledge and experience showed a widespread sense among questionnaire respondents that despite all the difficulties, progress had been made in terms of the growth of what could be termed ‘professional expertise’.

As the questionnaire survey indicated, the subjective self-assessment of pride in clinical work, professional knowledge and its applicability were rated rather highly:

- 46% of respondents believed that the quality of patient care today was the same as it had used to be in the period prior the reforms. At the same time 32% thought that the quality of patient care had improved and just a minority (7%) said that it had worsened.
- Quite similar results were obtained to the question about the quality of clinical care. It had increased, from the point of view of the 41% of the doctors, had seen no changes for 38% and had worsened just for 5% of respondents.
- 56% of respondents argued that now they could use their knowledge and qualification as effectively as they had done before the reforms started. 28% said that the opportunities to get most of one’s experience and knowledge had increased. And only 5% stated that they had lost all the opportunities for development in the professional sphere.

However, if the ‘constituent’ elements of ‘professional expertise’ are considered closely, such as the opportunity to take refresher courses, and the frequency of reading professional literature and periodicals, it may be that high marks given to the growing level of professional expertise referred to by doctors can be somewhat overstated. Thus, many respondents said that reforms have reduced the opportunities to retrain (see Table 5.15 below). As regards the professional retraining, the worst situation was shown in Komi region. In this region, the opportunities for training through attending courses had lessened for the 40% of medical practitioners: 22% had seen no changes and just 19% had had more chances to go through retraining. In Kirov, 23% of the respondents reported negatively about the possibilities for retraining. The reforms had not influenced the retraining opportunities for 28% practitioners and for 37% had improved them. The best opportunities for retraining were found in Moscow. For 42% of Muscovites

reforms had not had any impact on the opportunity to retrain and for the third part (36%) the reforms had widened the scope of opportunities to take refresher courses.

**Table 5.15: Opportunities to take refresher courses**

	Regions (%)		
	Moscow	Komi	Kirov
Worsened	6	40	23
Remained the same	42	22	28
Improved	36	19	37
DK	16	19	12
Total	100	100	100

Another indicator of ‘professional expertise’ – reading of the professional monographs and press testifies to the above mentioned idea that the optimism of respondents about the increased professional expertise was not well-grounded. Overall, one third of the respondents said they read the professional press seldom or did not read it at all. The data about the frequency and the scope of reading of the professional literature are presented in Tables 5.16 and 5.17 below:

**Table 5.16: Frequency of reading of the professional literature**

	Frequency (%)		
	Often	Rarely	Never
Monographs	30	40	7
Newsletters, information bulletins	47	34	3
Journals	58	29	3
Newspapers	44	34	8

In this Table more than one category could apply

**Table 5.17: Scope of reading of the professional literature**

	Regions (%)		
	Moscow	Komi	Kirov
Monographs	30	24	31
Newsletters, information bulletins	55	38	44
Journals	62	54	55
Medical newspapers	41	45	48

In this Table more than one category could apply



The frequency and scope of reading of the professional literature were often limited as a consequence of financial constraints of medical institutions and medical practitioners themselves. In the Soviet time, medical institutions subscribed to the professional literature and kept libraries. This tradition was largely broken after the reforms.

The unrealistic treatment of the level of professional expertise shown by many medical practitioners in the questionnaire can be explained by an intrinsic desire of a professional community to protect the positive image of medical profession. As it was discussed in Chapter III, despite low income and low professional discretion, medical practitioners in Russia were considered to be a part of a prestigious social layer of the intelligentsia. Similar to Western doctors, their work remained to be a 'status' profession to a certain degree. Weber argued that status communities are organised for the defence of their social privileges and entitlements. Status groups depend crucially upon the maintenance of a life style, and they seek to reproduce themselves through educational mechanisms, in order to prevent the social mobility of outsiders. Russian doctors did not have the control over training procedures and the entry into medical professions. However, they presumed a special position in the labour force and professional ideology (Freidson 2001: 130)

### **3.3.2. Professional ideology of altruism**

As it was discussed in Chapter I, professional altruism, taken as a social good at which the professional expertise is directed, was seen as an important characteristic of professionals by social researchers writing from various theoretical perspectives. Functionalist and trait writers saw professions as ethically positive embodiments of the 'central values' of the society (Goode 1960; Parsons 1968). Critics felt that this approach reflected too closely the ideological image which professionals tried to convey of their own work. However, neo-Weberian critiques, for example, have not denied the importance of the professional ideology of altruism, arguing that some of their actions may be self-enhancement, but the reverse side of the coin is still a service for their patients or clients (Saks 1999b).

As the questionnaire research showed, the respondents were disappointed with the reforms of the state health care sector. However, they were not disappointed in their profession. Overall 69% of the respondents said that they were not disillusioned with

medicine, despite the fact that 82% of them said that they were unhappy about their wage level. This proves that professionals try to produce a positive image of the medical profession taken as a commitment to a value to doing good work instead of economic gain. As shown in Table 5.18 below, satisfaction with the profession of medicine was high:

**Table 5.18: Disillusionment with the profession**

Disillusionment		Regions (%)			Total (%)
		Moscow	Komi	Kirov	
	Do not worry	74	66	62	67
	Somewhat worry	11	7	16	11
	Worry	7	16	12	12
	DK	8	11	10	10
	Total	100	100	100	100

Questions on the feelings of respondents towards their work showed that the profession itself supported professional values. Most respondents, almost two thirds, stated that their work motivation did not depend on income. They were committed regardless of income (see Table 5.19 below). Of course, a proclaimed ideology should not be mistaken for reality. Nevertheless, it is worth noting that regardless of the reforms, doctors still wish to be seen as supporting a professional ideology of altruism.

**Table 5.19: Work motivation**

	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
My work is a contract: the more I am paid for, the more I do	11	11	10	11
My work does not depend on the income I earn. I do all I can regardless of income	62	61	59	61
My work is a necessity. If I had money from other sources, I would not work	11	13	12	12
I like my job, but my family (household duties, hobbies) matter most to me	11	9	10	10
DK	5	6	9	6
Total	100	100	100	100



Following the functionalists and trait writers, professionals were supposed to see their work as a kind of mission or calling. Unlike people whose work was considered to be an occupation, and who were taken to lack the feeling of ‘commitment’ to their work-activity, professionals were assumed to remain committed to an area of work during their life span. Members of the profession were less willing to leave an occupation, and were more likely to assert that they would choose the same work if they were to begin again (Goode 1957). The status of medicine as a career choice was also still significant to the questionnaire respondents. About one third of them (less in Kirov, more in Moscow) were ready to advise their children or other close relatives to follow a career in medicine. Although in the provinces the proportion of those who would not give such advice to close people is larger, this reflects the greater opportunities that exist in Moscow, as can be seen in Table 5.20 below.

**Table 5.20: Advice to follow a career in medicine**

	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
Ready to advise	44	30	18	35
Would not advise	34	50	63	45
DK	22	20	19	21
Total	100	100	100	100

In summary, the research showed that most Russian doctors did not gain power in the economic and political dimensions. Rank-and-file doctors did not exercise the right to determine their remuneration and to make independent policy decisions as the legitimate experts on health matters. However, medical administrators (head doctors) reserved the right to set their own standards and control clinical performance, exercised, for example, through professional control over working conditions, allocations of money earned in self-financing departments and collegial control over discipline and malpractice. They also exercised some control over the organisation of medicine in their medical institutions. And private practitioners gained more freedom to determine terms of work under the rubric of clinical autonomy. What was also important, was that professional group identities had not been entirely ‘wiped out’: Russian doctors used their professional expertise and professional ideology of altruism to produce a positive image of the medical profession. And the profession itself and professional values, despite all the shortcomings of the reforms, still were important. Overall, medical

practitioners were dissatisfied with their current social position and wanted to redefine it. Some possible strategies of professionalisation are considered in the next section.

#### **4. Professionalisation of medical practitioners**

As was discussed, most medical practitioners said that medical associations were not sufficiently strong and active in their regions. During the Soviet era, as was the case with many professional bodies, the few medical associations in existence were essentially coopted by the Soviet authorities (Schechter 1992; 2000). Since then, most professional associations of medical practitioners have not represented an autonomous political voice. However, it may be argued that some newly organised All-Russian professional associations have moved beyond the Soviet-era status. The content analysis of the medical press showed some professional associations proclaimed professionalisation among their goals.

There has been an evident trend of the resurgence of professional associations and the corporate work of doctors for the redefinition of their rights and obligations. For example, this is illustrated by the organisation of the Russian Medical Association (RMA) set up in 1992, which nowadays unites doctors and other health workers all over the country and has a well-developed regional infrastructure. In 1995, the Russian Medical Association initiated and organised the first (XVII) All-Russian Pirogov Congress of Physicians. This was the first meeting of the Congress for more than eighty years. The congress welcomed 600 delegates and more than 500 guests from all over the country. The number of participants at the subsequent second and third Pirogov congresses grew. More than 2000 delegates took part in the former in 1997. 1423 delegates and 600 guests took part in the third Pirogov congress in 1999 (Komarov 2001).

The content analysis of the *Doctor's Newspaper* (1998-2003) highlighted the fact that the RMA strives for the status of a 'political' association, which aims at influencing a broad spectrum of the health sector problems. The main goals of the RMA, under which auspices the Pirogov congresses have been held, were proclaimed as the following (Doctor's Newspaper 2001):



‘Assistance [to the state] in the solving of the vital problems of the health sector, medical science and education, production and mastering of medical technical appliances, pharmaceutical industry, ecology, formation of the moral principles of the society, introduction of our country’s and foreign medicine achievements, creation of the favourable conditions for the realisation of national humanitarian and charitable activities throughout Russia’.

Thus, the RMA suggests that assistance of the medical profession should be given to all spheres of health work from the supervision of the pharmaceutical industry and the introduction of new medical achievements to the advancement of moral principles within Russian society. This follows the views supported by earlier Russian and Soviet intellectuals. The status of the intelligentsia has always implied support for broader principles as well as just professional functions. It has meant a special cultural mission involving the dissemination of values and knowledge associated with the practice of a particular form of work (Mansurov and Semenova 2001). Before the October Revolution the physicians, especially the members of the Pirogov society, saw themselves as a critical and creative social force that, above all, developed and protected societal morals and values. They also acted as social critics. In the Soviet period, the physicians had not stopped generating what Bourdieu has termed ‘cultural capital’ (Bourdieu 1990), however, they could no longer criticise the political elite. The reforms of 1992 changed this situation, bringing more scope for the development of a wider role of the medical profession, including the role of social critiques.

The content analysis of the medical press showed that heads of medical professional associations considered two options for the enhancement of the social standing of their professional group (Komarov 2001; Sarkisyan 2001). Some doctors, mostly state employees, hoped that the state would enhance the status of medical practitioners by increasing autonomy and decision making powers – representing ‘professionalisation from above’ (McClelland 1990: 107). Other doctors, mostly private practitioners, considered another option referred in social literature as ‘professionalisation from within’, namely the independent development of private medicine from the state, which would mean a legal monopoly in the market: passing over to the professional associations the power to determine training standards; requirements for certification and licensure; and the licensing procedures themselves (McClelland 1990: 107). This is

similar to the classical model of professionalisation of the British medical profession. Differences and similarities of the goals of the two major All-Russian medical associations, namely – the Russian Medical Association which unites state employees and the Russian Association of Private Medical Practitioners – are illustrative of the two above-mentioned options for enhancing social standing, as the former association is more oriented towards ‘professionalisation from above’, whereas the latter strives for ‘professionalisation from within’.

#### **4.1 Professionalisation from above: Russian Medical Association**

As the analysis of the resolutions and other documents of the Pirogov congresses showed, the Russian Medical Association had severely criticised the state, first, for weakening state control of the health sector, while the non-state mechanisms of the regulations of public health had not yet developed (Komarov 2001). Second, the RMA had blamed the state for the substitution of the system of the state financing of the health sector with the insufficient system of compulsory medical insurance. When the members of the RMA talked about their own rights they mainly aspired for participation either in federal or in local departments of the Fund of Compulsory Medical Insurance. The doctors insisted that the members of the RMA were included in these departments and were drawn into the central and local legislative political bodies for (1) drawing up and adopting of the main legislative documents as regards the health care sector (programmes, laws, concepts); (2) working out the professional standards of practice and the main principles of the licensing and accreditation of the medical institutions and certification of doctors. However, the RMA insisted that their participation in the legislature and licensing procedures should go hand in hand with the reinforcement of the state control of the health sector (Sarkisyan 2001).

The RMA had referred their suggestions to the various state organisations, among them the Ministry of Health of the Russian Federation, the President, the Parliament and the State Duma. These higher authorities to whom the participants of the Pirogov congresses had referred, however, did not respond to the concerns of the congress participants (Komarov 2001). This lack of mutual understanding between the state and the profession was mirrored in the resolutions of the three Pirogov Congresses which were not virtually changed from the first Congress to the last. In brief, the resolution of the delegates of the III Pirogov Congress is presented below (Sarkysian 2001):



- The worsening of the health of the Russian population can be considered a national catastrophe and requires immediate in-depth measures on the part of the state. The Congress advises that the Minister of Health should be a member of the National Security Council. Health protection must become a priority for the state and must be put under the control of the President of Russia.
- The state budget investments into the health sector must be increased up to 6% of the GDP. The allocations to the Fund of Compulsory Health Insurance should be raised from 3.6% up to 7.2%, which would bring Russia into line with other European countries.
- The Congress recommends the President and the Parliament to inform the population of the country about the measures taken to improve the general situation in the health sector.
- The Congress announces that the rights and economic conditions of the physicians, nurses, as well as medical scientists, scientific and medical personnel who work in the higher medical education institutions and their students do not correspond to their contribution to the development of the society. The vicious system of back wages should be eliminated. The socio-economic conditions of all health workers must be improved. The average salary in the health sector must be equal to the average salary in the industry.
- The Congress argues that there is a distinct need for the state organisation of the single countrywide medical information system which would provide an opportunity for close cooperation of physicians and their influence on the health promotion and prevention of ill-health. The information net should draw in professional periodicals, TV programmes, Internet sites and publishing houses.

As the above-mentioned resolutions of the Pirogov Congresses highlight, the RMA was mainly concerned with the issues of the health of Russian population in general, while their own professional corporate interests came second. Considerable attention was devoted to the facts of increased health problems of the population: decreased birth rates, growth of the infectious diseases, low life expectancy. Moreover, the members of the RMA have challenged state health policies, mainly those concerned with the introduction of the compulsory insurance system. Thus, it may be argued that the interaction of the RMA with the state is already very different from the strategy of trade unions, generally concerned with improvements in salary and working conditions. However, the members of the RMA have not yet attempted to introduce macro-changes

such as an extension of private medicine or changes in health care funding through the insurance system. Rather, they have supported minor reforms which would improve the situation gradually, imposing the responsibility on the state.

#### **4.2. Professionalisation from within: Russian Association of Private Medical Practitioners**

Changes in the social attitudes of the private medical practitioners and the growth of their aspirations for increased autonomy could possibly lead to the development of a professional ideology, a collegiate culture and, in the long run, a transformation in their social standing. As the resolutions of the first Russian Association of Private Medical Practitioners formed in May 2001 showed, private practitioners, search for more radical changes in the health sector. The goals and purposes of this association are more proactive than the aims of the Russian Medical Association. The main goals of the association stated in its resolutions touch upon the following issues (Komarov 2001):

- The introduction of a single register of private practitioners. The local branches of the association should be opened and should keep registers of medical practitioners as well as the information about their successes and failures – as indicated for example by medical negligence cases. The register would help the association to recommend the best practitioners to the medical insurance associations and the Ministry of Health for the purpose of making contracts with the best private medical institutions and private practitioners.
- Participation in the accreditation procedure. The members of the Association must by all means participate in the procedures of licensing and accreditation of private practitioners to protect doctors from arbitrary and unjust decisions by bureaucrats.
- The regulation of prices on the medical market should be passed into shared regulation of the Ministry of Health and the association, for the purpose of the prevention of the dumping of prices as a consequence of the faulty economics of the Ministry of Health. The state gave an advantage to the state self-financing departments, which work under the privileged conditions compared to the private practitioners (e.g. qualified doctors state employees who render fee-for-services do not undergo accreditation procedures, as against qualified doctors who render independent private services). More than that, the prices on the services of the self-financing departments are still fixed on the 1991 base.



- Arbitration courts that would deal with cases of the medical negligence of private practitioners should be introduced.
- Adoption of laws on the private practice, as fee-for-service practice should become available to the population with the help of change in the system of financing of health care. The major sources of investments into the development of the private health sector are seen as the combination of compulsory and voluntary medical insurance and partial budget financing.

Thus, the Russian Association of Private Medical Practitioners called for more far-reaching changes than the association of their state employed counterparts. Following Burrage and colleagues (1990), professionalising Russian private medical practitioners can be defined as a 'regulatory association' that seek to regulate the members of the profession, to examine and certify them and negotiate on behalf of their members. Private practice still does not have a well-defined economic and political status. However, private medical practitioners have acquired greater control over the content of their work and their working conditions. They are also better placed to control the tempo of their work. In the future, it is possible that private practitioners will outstrip state practitioners in the realisation of the goals of their professional organisations.

## Conclusion

This chapter has demonstrated that health care reforms oriented to privatisation created a new dynamic and opened up new opportunities for doctors to improve their social standing. It was shown that the majority of orthodox medical practitioners who participated in the research, were discontented with the social standing of medical profession and sought to redefine it. The research revealed that doctors fell into two groups, one anxious to proceed along the Western-style, market-reform path, and the other determined to preserve what they saw as the positive elements of Soviet style health care. Most state orthodox medical practitioners aimed at sharing regulatory responsibilities with the state. In contrast, private orthodox medical practitioners were more willing to achieve relative autonomy from the state and pushed for self-regulation. The attitude of state and private Russian orthodox medical practitioners to the growth of alternative medicine and its possible professionalisation is discussed in the next chapter.

## **VI. THE STATE REGULATION OF ALTERNATIVE MEDICINE AND THE RESPONSE OF ORTHODOX PRACTITIONERS TO ALTERNATIVE MEDICINE**

In the previous chapter the development of the orthodox medical profession in the period of recent reformation of the health sector in Russia was discussed. It was shown that the reorganisation of the health sector created the necessary prerequisites for the professionalisation of the orthodox medical profession. But most Russian orthodox medical practitioners did not take up the opportunities given by the emerging markets and preferred to remain in the position of state employees, as this provided a more secure social standing, guaranteed a stable income and a pension. The professionalisation process was understood as a collective professional project aimed at extending the social position of a professional group that remained relatively weak. The creation of new professional ideologies and professional associations is at an early stage of formation. However, today orthodox medical practitioners occupy a higher position in a professional pecking order than their alternative counterparts and lay practitioners. As against alternatives, the orthodox medical profession has a guarantee of state employment with a stable, even if low, income and social benefits and orthodox doctors are accorded some professional prestige.

This chapter considers the response of the Russian state and the orthodox medical profession towards alternative approaches in medicine. It starts with the discussion of the development of alternative medicine among medically qualified practitioners and lay practitioners from the 1980s up to the present. It then analyses the dynamics of the state response towards the development of alternative medicine on the basis of statutory documents and statistical data from the Ministry of Health in the Russian Federation. The chapter then investigates the scope of knowledge of, and interest in, alternative medicine among Russian orthodox doctors, drawing on data from the INTAS research on practitioners within three Russian regions: Moscow, Komi region and Kirov. It looks in more detail at the medically qualified doctors who also practise some kind of alternative medicine. Their personal characteristics such as gender, age, specialty, length of service, and administrative position are specified. Finally, the chapter examines the views of conventional doctors on the validity of alternative medicine,



whether they referred their patients to alternative practitioners and to what extent they were ready for the wider integration of alternative medicine into the state sector.

The chapter is based on the INTAS research '*Russian Doctors: their Attitudes and Strategies for Adaptation*' conducted by De Montfort University, Leicester (UK) and the Institute of Sociology of the Russian Academy of Sciences, Moscow (Russia). Field research for this study was conducted in January 2001 and included questions on alternative medicine (for more detail see Chapter IV 'Methodology and Methods'). Until this INTAS-based research, there had been no surveys on the response of orthodox practitioners towards alternative medicine in Russia. In contrast to European countries, where the increasing interest in alternative medicine of Western doctors trained in biomedicine had been widely reported in the social science literature (Reilly 1983; Wharton and Lewith 1986; Anderson and Anderson 1987; Perkin, Percy and Fraser 1994; Saks 2003a). In this chapter, the response of the orthodox medical profession to alternative approaches in the West will be briefly referred to, to illuminate the differences in the evolution of the attitudes of the state and orthodox profession towards alternative medicine in Russia.

## **1. The revival of alternative medicine from the 1980s in Russia: an uncertain social status**

One variant of systems theory that has tried to explain the life and development of social, technical, and biological systems claims that 'any innovation appears under two major conditions, where there is a demand for the change in the old system and there are opportunities to satisfy the demand' (Altshuller *et al.* 1987: 25). For example, while the dream of being able to fly had existed for centuries, the actual demand to cover great distances came in the marketplace at the end of the nineteenth century when technical progress led to the development of the airplane. The notion about there being two prerequisites for a new social phenomenon on the demand and supply side resonates with the view of Sharma that two aspects account for the resurgence of alternative medicine: the increased demand of users and the growing supply of alternative therapies in the market (Sharma 2000: 217). On this basis, the balance of demand for, and supply of, alternative therapies in the recent revival of interest in alternative medicine is considered further in Russia.

## 1.1. Demand for alternative services in Russia

From the 1980s onwards, alternative medicine in Russia underwent a resurgence despite its longstanding marginalised position during the Soviet period. There is a range of indicators of this trend. Similar to Britain, these include increasing over-the-counter sales of unorthodox remedies and the rising uptake of alternative medicine by the public (Bakx 1991). There is a national variation in the use of alternative medicine with, for example, between a fifth and one half of the population of Western countries typically going to consult an alternative therapist at some point in their lives (Saks 1997a: 201). According to recent research in Russia, about a quarter of Russians have consulted with alternative therapists (Fund of Public Opinion 2002). And this figure seems to be underestimated, as a result of the problem in the questionnaire design. The question was asked: 'Have you ever consulted with specialists in alternative medicine?' with the explanation given in parentheses, which said 'e.g. healers, herbalists, extrasensory individuals and others'. The respondents were supposed to comment on the answer whom exactly they consulted. These answers showed that the majority of them did not know that homoeopaths, acupuncturists and osteopaths were also included into the category of 'alternative medicine' (the issue of definitions was discussed in Chapter II). It can be deduced from this survey that *more* than a quarter of Russians had consulted with alternative therapists.

Nobody explicitly decided that health care should become more pluralistic in the 1980s in Russia, but the medical monism of the mid-twentieth century was seriously eroded at the time (Karpeev and Kiseleva 2002: 7). In the late 1980s, indigenous Russian traditional medicine – herbalism, hirudotherapy (the employment of leeches as a therapy), apiotherapy (use of bees for therapeutic purposes) – was replenished by new non-conventional therapies ranging from developed systems of theoretical knowledge such as acupuncture, osteopathy and Ayurveda to more limited therapies such as aromatherapy. The Soviet people who had pined for bright unusual events appreciated the appearance of alternative therapists and, most of all, the advent of healers, extrasensory individuals who claimed to heal illnesses of every sort and kind.

Healing was in the lead as far as the first consumers of alternative medicine were concerned. And today healers comprise almost half of all Russian alternative



practitioners (Berestov 2001: 12). Early healers with self-proclaimed supernatural powers believed that healing could occur at a distance based on using their energies for therapeutic purposes. Some of them managed to get prime time on television. Many Russians watched healing sessions and even put bread, water, clothes, photos, and money in front of their televisions, hoping to 'charge' these objects with psychic energy for health enhancement (Galperin 1995: 6). In the Ministry of Health archive, many letters evidenced health improvements among the television audience. There were letters too, however, which testified to the detrimental effects on health and some doctors reported that after the television programs there were increasing numbers of patients with acute conditions (Berestov 2001: 12). As a result of the complaints of patients and doctors, television healing sessions were prohibited. It was impossible, though, to prohibit healing. One famous healer, Kashpirovsky, became the most popular man of 1990, was included in encyclopaedias and reference books and was elected the Deputy of the State Duma (Berestov 2001: 13).

Acupuncture and osteopathy became almost as popular as healing before the demise of the Soviet political system. For example, a hereditary Ukrainian bone-setter Kasyan was as famous as Kashpirovsky. Thousands of visitors came daily to his village to be put on a waiting list for his therapeutic sessions. His reputation and the popularity of a few other non-medically qualified bonesetters spurred the scientific development of osteopathy (Sitel 2003: 2). Acupuncture, on the contrary, was concentrated only in the hands of medically qualified doctors. This therapy had already become popular, especially amongst high-ranking politicians, who had access to it since it first emerged from obscurity in Russia in the 1950s with the development of political links between China and the Soviet Union (Kao 1973; Saks 1995b: 200-201). Then it disappeared from the limelight as ideological divisions widened in the 1970s and it recovered its popularity and became more widely available in Russia in the 1980s.

Homoeopathy had also held sway among medically qualified practitioners in the Soviet period and was available for a limited party clientele, although it was the only alternative therapy officially banned by the Soviet power in 1938 (Kotok 2001: 31). In the 1980s, information about the effectiveness of homoeopathy circulated by word of mouth and many wanted to try it. The interest in homoeopathy was paralleled by an interest in natural non-drug therapies and a naturopathic movement. Naturopathy came

to Russia as a health movement based on a desire of patients to re-examine their day-to-day lives and adopt a healthy life style. As Viilma argues some naturopaths taught that to think positively led to health (Viilma 2000: 24). Others said: 'learn new breathing techniques and you will be healthy'. Or third: 'change your food habits and you will be healthy'. Fourth, 'exercise and you will be healthy'. Many Russians were concerned with all of these dimensions – food, breathing and exercise, and were ready to participate in health enhancement groups marked by the moderate and rational consumption of food and positive thinking (see, amongst others, Brushlinskaya and Pazilova 1991: 50-56). Other alternative therapies from aromatherapy, colour therapy and hydrotherapy to Ayurveda also became popular, although they did not become as widespread as the above therapies, which were used on a self-help basis and were practised and researched on a small scale in the Soviet period (Karpeev and Kiseleva 2002: 88).

## **1.2. Reasons for the growth of demand for alternative medicine**

Let us start the analysis of the reasons for the growth of alternative medicine in Britain, as this trend has been thoroughly analysed by social scientists, unlike Russia where the revival of alternative medicine has not yet attracted attention from social researchers. This will provide a helpful backdrop for understanding the resurgence of alternative medicine in Russia, which had some similarities and some differences with the processes that took place in the West.

### **1.2.1. Reasons for the growth of demand for alternative medicine in Britain**

The key social scientists writing on the subject trying to find the diverse currents that had brought about the growth of demand for alternative medicine in Western countries singled out the cultural, economic and political components (Bakx 1991; Fulder 1996; Sharma 2000; Saks 2003a). The growth of demand for alternative services occurred in the period of wide social changes in the West, when growing numbers of the public sought to escape from established patterns of deference to authority and to explore alternative lifestyles (Saks 1998: 199). This trend was linked with the upsurge of a medical 'counter-culture' understood as a subculture set up in opposition to the dominant culture of medicine (Saks 2003a: 107-108). The medical counter-culture



strongly manifested itself in the West in the 1960s, where the dissatisfaction with biomedicine, technical deficiencies of orthodox medicine and iatrogenetic effects became evident (Sharma 2000: 213). By that time the critique of medicine had been in process for more than 20 years as an undercurrent in the European countries, since the early work of Rene Dubos, who wrote of 'medical utopias' and the 'mirage of health' by noting that whatever progress is made in medical research, 'complete freedom from disease...is almost incompatible with the process of living' (Dubos 1959:1). The first critics of modern biomedicine showed uncomfortably clearly that like all other medical systems, modern medicine had areas of failure along with areas of success (Illich 1976; McKeown 1979; Pietroni 1995). These authors drew on the then contemporary evidence and argued that the resources ploughed into health were rising steadily, while the human lifespan remained unchanged, and the population became sicker<sup>24</sup>.

The counter-culture provided a platform for patients to exert rising pressure for greater professional accountability in orthodox medicine. The growing confidence of the informed and increasingly consumerist patient has been increasingly recognised in representational roles both on professional bodies and within key committees in the health sector (Allsop 1995; Cant and Sharma 1996a). Other counter-cultural actions took place in the self-help field: 'the growing trend to take on self-responsibility for health have covered everything from the widespread purchase of stationary exercise cycles to enhance personal fitness to annual efforts by large numbers of smokers to desist from their habit to improve their health' (Goldstein 2000). Self-help movements have had various manifestations: the health food movement, Crawford's 'healthism', what Coward calls the 'consciousness industries' and the stress on citizens' duty to limit their demands on the public health care system (Coward 1989). Thus, the strongest consumer-led counter-cultural development in health stemming from the mid-1960s brought about the rising public interest in the diverse array of alternative therapies (Clark 1990; Lewith and Aldridge 1991; Saks 2003a).

Sharma also drew attention to economic and political factors that led to a growth of demand: the increase in disposable income enjoyed by a large section of the British middle class during the eighties (Sharma 2000: 213). First, the re-emergence of

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<sup>24</sup> Although this was also an ideological interpretation of health matters, as in fact many people were living longer and the life span was increasing (McKee 2001).

alternative medicine started out as a middle-class movement, the prerogative of those who could afford private consultations (Fulder and Munro 1981). Second, alternative therapies in Britain have received growing political support, which is highlighted by the establishment of the all-party Parliamentary Group for Alternative and Complementary Medicine and the creation of special ministerial responsibilities in this area (Saks 1997a: 202). Prince Charles has supported alternative medicine in Britain by the production of a national document to promote integrated health care and prompted medical research into this area (Foundation for Integrated Medicine 1997).

### **1.2.2. Reasons for the growth of demand for alternative medicine in Russia**

The concept of the medical counter-culture understood as a subculture set up in opposition to the dominant culture of medicine that was established in the 1960s in the West (Saks 2003a) was applicable to the situation in Russia in the 1980s. At this time, alternative medical knowledge was welcomed as part of a search for new values with the economic reforms leading to the introduction of the market and the strengthening of the liberal democratic state in terms of public opinion. As in Western societies like Britain two decades earlier, where alternative life-styles developed in an era when established practices of all kinds were critically scrutinised (Saks 1997a: 201), the interest in traditional Russian medicine and new alternative therapies reflected the spirit of times and was based on the desire to step outside of the ordinariness of everyday life. As has been seen, there were various indicators of a counter-culture opposed to medicine from the popularity of healing and naturopathy to increased reliance on self-help (Neumivakin and Neumivakina 2000; 2001). While the protest against dominant values in Western society was connected with Eastern mysticism and meditation, in Russia it was paralleled by the revival of established orthodox religion. By 2001 in fact 70% of Russians considered themselves to be Christian Orthodox, and 66% of them trust the Christian Orthodox church (Russian Public Opinion and Market Research 2001).

The decline of the Soviet regime was accompanied by discontent with Soviet socialised medicine, which was – like Western medicine – highly reductionist, symptom-based and illness-oriented. Davis argues that the health service in the USSR had many characteristics in common with Western countries as a result of universal influences: the



biomedical scientific approach to disease, the acceleration of technical progress, and growing specialisation in the medical field (Davis 1989: 233). However, the medical counter-culture would not have manifested itself so strongly in Russia, if the shortages of medical equipment, machinery and instruments in the health care throughout the Soviet period had not been exacerbated during the reforms (Allsop *et al.* 1999). In the 1980s, the drug supply covered only about 20% of patient requirements, while equipment was old and overloaded (Rasumov 1994). This left considerable scope for alternatives, and doctors were becoming increasingly interested in natural, low-cost therapies, not so much because of a holistic vision, as from the practical concerns of delivering health care in difficult circumstances (Agnew 1991; Andrews 1991).

There were some differences in the upsurge of demand for alternative medicine in Russia and Britain. The re-emergence of alternative medicine in the latter started out as a middle-class movement, based on those who could afford private consultations (Fulder and Monro 1981). This contrasted with Russia, where very powerful social strata and poor services prompted the revival of alternative medicine. As a result, Russia had not yet experienced the corresponding empowerment of the consumer that occurred in Britain, where more patients could afford to purchase medical services, had higher expectations of the quality of private medical services and participated in representational roles within the health service (Allsop 1995). In Russia, the power of the health consumer was still limited by finances. Only a small number of Russians became more consumerist and could choose whether they would be treated by their local general practitioners or privately by alternative practitioners, as most of the latter do not provide free services.

Thus, in Russia, similar to other European countries, demand for alternative medicine represented a challenge for the medical mainstream expressed in a counter-cultural onslaught against modernist conceptions of technocratic rationality and a belief in biomedical science (Harvey 1989; Saks 2003a). By the 1980s, the Russian medical profession could be regarded as illustrative of an occupation that had secured a privileged position in the state health care sector. However, at this point the challenge posed by outsiders contested the boundaries of orthodox medical knowledge and the medical establishment had to begin to defend its own professional interests.

### **1.3. Supply in the emerging market for alternative medicine in Russia**

By the 1980s, the number of Russian lay alternative therapists practising healing, herbalism, bone-setting, hirudotherapy and apiotherapy was higher than in any Western country (Fulder 1996: 106). This can be explained by a stable demand for lay alternative practitioners. Official Soviet medicine in rural areas had been starved of resources, and part-time, lay, alternative practitioners supplied patients with the necessary help starting from cupping, 'plasters', and hydrotherapy to more sophisticated herbalism (Davis 1989: 247). Since the Revolution of 1917, there had been a distinct separation into orthodox and alternative medicine. Orthodox biomedicine, largely centred on the use of drugs and surgery ousted Russian traditional medicine into the lay sector, where it turned into 'alternative', as it was not typically supported by the state through research funding and inclusion in education and training programmes for the orthodox health professions (Saks 1994). These lay alternative practitioners were not forbidden by the state, although they lacked state sanctioning, they could not practise in state medical institutions and were mostly confined to the rural private fee-for-service sector.

The number of lay therapists as well as their status in the eyes of health consumers started to grow in the 1980s, due to an unprecedented rise of interest of the Russian population in alternative medicine. These trends started to represent a real threat to the hegemony of the medical profession, as the demand for alternative services increasingly came not just from underprivileged rural health consumers, as it was in the Soviet period, but from the majority of the population, including elite groups. With the growth of lay practitioners and the increased popularity of alternative medicine, leading figures from the Ministry of Health in the Soviet Union took a more supportive stance in relation to alternative medicine. It was untenable for the state simply to discredit lay practitioners and outlaw them, especially with the worsening general state of affairs in the state health sector. The Ministry of Health therefore claimed that the supply of medically qualified doctors with knowledge of alternative medicine should be increased to the point where there would no longer be demand for lay alternative therapists (Karpeev and Kiseleva 2002). Thus, the Ministry of Health in the Soviet Union sustained the continuing dominance of biomedical authority through a strategy based on the incorporation and subordination of alternative medicine, in face of the growing challenge from CAM. This has parallels with the British experience (see Nettleton 1992; Saks 2001).



It may not be justified, however, simply to see the efforts of the Ministry of Health of the Soviet Union to increase the supply of medically qualified doctors with knowledge of alternative medicine, as in the self-interests of orthodox medical practitioners in maintaining their dominant position in the medical professional pecking order. At the time, the growing demand for alternative therapies and the rapid growth of lay alternative practitioners was followed by the rise of 'quackery', where substantial harm could be caused by practitioners, who had little or no knowledge of biomedicine and/or the therapies they were purveying (Saks 2003a: 156). In the sense, it might be said that the Ministry of Health had to protect the wider public from 'quacks', practising a spurious medicine solely for the pursuit of profit. Against this, as Beier and McGray argue, the notion of a 'quack' has always been a necessary foil for doctors in pursuing self-interests and claiming to be 'professionals', practising genuine medicine for the benefit of the patient (Beier and McGray 1981: 30).

The first steps taken by the Ministry of Health of the Soviet Union to increase the supply of medically qualified practitioners with knowledge of alternative therapies were to introduce training in the most popular therapies of osteopathy, acupuncture and homoeopathy. In the 1980s, hardly any Russian doctors knew what osteopathy was, but many wanted to learn. The Ministry of Health had to invite outstanding osteopaths from Czechoslovakia to start the first training course and open the Centre for Osteopathy (Sitel 2003: 1). The number of courses was not sufficient, and many orthodox practitioners had to wait up to three years to subscribe. Only the best doctors could specialise in osteopathy – all those aspiring to train had to receive special permission from the Minister of Health or his deputy (Sitel 2003: 2).

To start training courses in homoeopathy and acupuncture was easier, as the therapies had been practised by a few orthodox doctors during the Soviet time. Acupuncture was used legally and homoeopathy – illegally. Since the early 1980s, homoeopaths had started to press for state recognition and permission to organise courses in homoeopathy. The first success came in 1984 when the Ministry of Health gave permission to organise the first course in homoeopathy (Ministry of Health 1984). However, official permission to practise legally was only obtained by homoeopaths in 1991 (Ministry of Health 1991). The first courses in acupuncture were organised in the

mid-1980s with the preparation in the hands of doctors who had previously researched and practised the method on a limited basis.

Thus, the Ministry of Health of the Soviet Union took control over the supply of alternative practitioners. It permitted, and helped to organise, the training of alternative medicine at postgraduate level from the 1980s. Since then the question has arisen whether alternative medicine should be taught within the medical school curriculum. However, such training is still left to the post-qualification period. Despite limited opportunities to train in alternative medicine, the efforts of the Ministry of Health were not in vain, as the number of medically qualified alternative practitioners has substantially grown. According to the main specialist of the Ministry of Health on alternative medicine, 5.000 doctors practised alternative therapies full-time within the state sector in 2003 (Karpeev interview 2003). Moreover, the INTAS-research highlighted that in 2001 about 47% of doctors from three Russian regions practised alternative medicine part time.

## **2. Increased state regulation of alternative medicine from the 1990s in Russia**

### **2.1. The statutory position of alternative practitioners**

In the late 1980s, the Ministry of Health of the Soviet Union tried to 'persuade' the Russian population to resort to medically qualified alternative practitioners instead of lay alternative practitioners. Periodicals and special television programmes often denounced the latter. However, the demand for non-medically qualified alternative practitioners remained unchanged. Increased opportunities for the training of orthodox doctors who practised alternative medicine did not stop the growth of lay alternative practitioners. Eventually, in 1993 the first law on alternative medicine was adopted, which proclaimed that only medically qualified doctors who received state registration could practise alternative therapies (State Duma 1993a). Only one group of lay non-medically qualified practitioners was exempt, namely those who were officially termed 'folk healers' who could prove that they had a special gift for healing or that their knowledge in traditional medicine such as bone-setting, herbalism or hydrotherapy was inherited from their ancestors (State Duma 1993b).



To obtain the right to practise, according to the Russian legislation, these healers had to apply for the status of 'folk healers' and a diploma to give them the right of legal practice. However, this law has given place to various interpretations, as it ambiguously specified the requirements for a diploma. It proclaimed that a practitioner with little or no medical education was allowed to practise under the following conditions: he/she had undergone examinations set by the All-Russia Professional Medical Association of Folk Healers and Specialists in Traditional Medicine or an equivalent regional association to prove his/her unique abilities and was given a recommendation (Galperin 1995: 34). Technically, the recommendation gave the right to apply for registration by the Ministry of Health and receive a 'diploma of the folk healer'.

In reality, this scheme has hardly worked in any region, as folk healers either did not seek a legal status or could not obtain it. A representative of the Ministry of Health of the Russian Federation explained in an interview given to the author that the Ministry received letters of complaint from the regional Ministries of Health that they were not given any criteria for the assessment of folk healers and did not understand to what diplomas they were eligible (Karpeev interview 2003). Folk healers, in turn, seldom needed to have a legal status. On the one hand, the consumers were accustomed to lay practitioners having practised for centuries without any permission from the state. On the other hand, 'folk healers' had learned to use subterfuge – they acquired a license for commercial activities, for example, for sociological or psychological consultations and then treated patients (see Moskovsky Komsomolets 2003). The majority of consumers of their services were not informed enough to determine what kind of certificate the practitioner had.

The situation became even more complicated in 1998, when healing – defined as the direct transmission of psychic energy for therapeutic purposes – lost its legal status and was excluded from the permitted list of therapies for practice in Russia (Ministry of Health 1998). This new statutory decree outlawed the majority of 'folk healers'. However, the law issued by the State Duma was not repealed. Consequently, even folk healers involved in healing could still take exams through their own associations and demand diplomas from the Ministry of Health. As a result, two contradictory laws put medical authorities in a position where they no longer understood what they should do

as regards to folk healers. One of the officials of the Ministry of Health of the Russian Federation commented as follows on the situation:

‘The law was very strange at the outset: the folk healers were assessing themselves on the basis that they themselves made up, and the Ministry had to give them state diplomas, which made little sense to me. And now the situation has gone out of control with the contradiction in their statutory position. We don’t understand whether we should prosecute them or give diplomas’ (Karpeev interview 2003).

To summarise, to date the practice of alternative medicine in Russia, except by statutorily recognised health professionals, is illegal, as it is in most states of the European Union, including Belgium, France, Spain, Italy and Greece (Vincent and Furnham 1998: 74). However, unless the law adopted by the State Duma in 1993 is abolished, Russian folk healers claiming to have a gift in traditional therapies and healing cannot be prosecuted by the state. In a similar way to Britain, today, therefore, there are many lay alternative practitioners who practise in the open market in Russia. They are mainly confined to healing and traditional Russian therapies, such as herbalism, apiotherapy, hirudotherapy and hydrotherapy. The majority of them claim to be healers, possessing extrasensory abilities. According to Berestov, 250.000 healers now practise in Russia, while in Moscow there is one healer for every 500 Muscovites (Berestov 2001: 34). All ‘foreign’ alternative therapies – acupuncture, osteopathy and homoeopathy – are mostly in the hands of medically qualified practitioners. The Ministry of Health succeeded in increasing the supply of doctors specialised in alternative medicine. Many Russian doctors came to non-conventional medicine, having become top professionals, doctors of science, inventors and State laureates in the sphere of biomedicine (for example, some of the respondents Neumivakin, Sitel, Vasilenko from the research undertaken for thesis). This is in contrast to Britain, where lay alternative practitioners greatly outnumber medically qualified alternative practitioners (Mills and Budd 2000).



## 2.2. Alternative therapies and state registration

The first list of therapies approved for practice by medically qualified doctors in Russia was adopted in 1996 and incorporated almost all methods within alternative medicine at the time (Ministry of Health 1996). This liberal decree on alternative medicine endured for about two years. Almost all alternative therapists who aspired to state registration could obtain it. Thus, in 1996 list of alternative therapies eligible for state registration in Russia were the following:

- Folk indigenous therapies.
- Chinese medicine.
- Tibetan medicine.
- Ayurvedic medicine.
- Systems of psychological health enhancement: music-therapy, aromatherapy, colour-therapy, meditation, and hypnotism.
- Systems of physiological health enhancement: breath therapies, massage; diet; naturopathy.

However, the permissiveness from the 1980s to the mid-1990s changed to a more austere approach in 1998, when all systems of 'psychological' health enhancement, Ayurveda, Chinese medicine (with the exception of acupuncture), Tibetan medicine and healing were forbidden (Ministry of Health 1998). As a result, from 1998, the list of alternative methods that might be subject to state registration included the following therapies (Karpeev and Kiseleva 2002: 125-28):

- Acupuncture;
- Homoeopathy;
- Osteopathy;
- Medical massage;
- Naturotherapy;
- Traditional medicine (apiotherapy, hirudotherapy, hydrotherapy, herbalism).

Officially, the decision of the Ministry of Health of Russian Federation to reduce the number of therapies was based on the fact that some of the therapies proved to have no coherent knowledge-base, standards for formal educational programmes and for practice, and their effectiveness was not based on any research (Kiseleva *et al.* 2000:

12). Medical authorities discredited some alternative practitioners, as they could not provide detailed descriptions of the medicines they used, the standard prescriptions and the possible side-effects. As such, the therapies that had the strongest philosophical affinity with the standards and *modus operandi* of orthodox biomedicine were the most successful in their relations with the state. It is not without significance that these represented the least threat to the interests of medical orthodoxy in terms of status, income and power.

Acupuncture and osteopathy had a higher standing than other alternative therapies, as they had developed for years under the patronage of the Ministry of Health. Acupuncture has been researched and practised by orthodox practitioners since the late 1950s and osteopathy since the early 1980s. They have modelled their training opportunities most closely on the orthodox medical profession. As a result, in 1997 acupuncturists and osteopaths won the right to inclusion in the State Nomenclature of Doctors and Pharmacists' Specialties as separate specialties (Ministry of Health 1997). This did not give them the fully enfranchised standing of orthodox medicine in the state sector, as they are still discriminated against in terms of research funding and do not figure in the curriculum of medical colleges. However, although there are still restrictions on the funding of acupuncturists and osteopaths, they have the right to open consulting rooms in state medical institutions and their services are free at the point of access for some categories of patients, with reimbursement through the medical insurance system (Ministry of Health 2002). Currently, in Moscow only one medical institution, the Centre for Osteopathy, provides the services of osteopaths free of charge. The Centre treats about 600 patients per day, and the waiting lists are very long. On average, patients had to wait for 3-4 months to get spinal manipulation (Sitel interview 2003). This situation to some degree parallels that in Britain, where osteopathy and chiropractic are the only two therapies which have achieved state registration (Sharma 2000: 216) – with consideration currently being given to acupuncture (Prince of Wales's Foundation for Integrated Health 2003). However, despite this mainstream acceptance in Britain, these new professions do not yet have privileged access to practice in the National Health Service (Saks 2003a: 150).

The patchy and localised provision of alternative medicine in the state sector is another parallel with Britain (Sharma 2000: 95; Karpeev and Kiseleva 2002: 1-10). Both



countries are far from a situation where the patient can opt for the alternative treatment of his/her choice and have the full cost borne by the state. In Russia, only acupuncture and osteopathy are free of charge if based on referral by a general practitioner or a medical specialist. All the other alternative therapies are employed on a self-financing basis, where patients or organisations themselves pay for services (Ministry of Health 2002). The decision whether to employ alternative practitioners may only be taken by head doctors of medical institutions. They have not seen employment of alternative practitioners as a top priority, as their knowledge of alternative therapies is limited, and they are sometimes prejudiced against unorthodox approaches. The situation in Britain is similar, as some forms of alternative medicine have become increasingly available locally on the National Health Service through a doctor – even if patients can access a broader spectrum of alternative medicine in Britain free at the point of access, where there are sympathetic medical practitioners/managers (Sharma 2000: 217).

### **3. The marginalised position of alternative medicine**

Despite the fact that a few alternative therapies have state registration in Russia, they still occupy a marginalised social position in terms of training and research. As discussed, training in alternative therapies is limited to the post-qualification level. There are no comprehensive courses on alternative medicine within the student medical curriculum as yet and there is no formal private college education for alternative practitioners (Kiseleva *et al.* 2000). During the qualitative interview research conducted by the author in 2003, nineteen prominent alternative therapists were asked whether they had ever read a course on alternative medicine in higher medical institutions. It turned out that only two experts had a chance to take a short introductory course on alternative medicine in one of Moscow's prestigious higher medical schools. However, they said that they came across opposition from their orthodox colleagues. They had both met with the students of the fourth and fifth years, and the students were deeply impressed by the lectures. According to these alternative practitioners, the administration of the medical institution became worried that famous alternative practitioners would make the students 'go astray'. The administration shortened the course from ten to five lectures, politely informing the lecturers that the curriculum was overburdened and some courses had to be excluded.

Russian alternative practitioners are also still disadvantaged in terms of research. Compared with Soviet times, when some alternative therapies were researched, the situation changed as funding for science was reduced. The low social status of alternative medicine resulted in the cutting back of resources for research. Today alternative practitioners find themselves in a position like that of their British counterparts in the 1960s and 1970s, where the medical world called for controlled clinical trials and at the same time generally refused to fund them or carry them out. Neumivakin and Neumivakina (2001: 6) argue:

‘The medical officials demand facts that would prove the efficacy of alternative therapies. They want us to do the research before the treatment, during the treatment and to estimate the results. I would not blame them for it. But this is too expensive, and alternative practitioners simply cannot afford it’.

In the author’s qualitative research, about one third of the nineteen prominent alternative practitioners said that they tried to apply for money to sponsor small-scale trials. However, neither the state, nor private pharmaceutical companies were interested in the financing of the research of alternative therapies. The interviewees said that they tried to do small-scale trials themselves using their personal contacts with orthodox doctors or medical bureaucrats from the Ministry of Health. These few attempts, however, could not provide a serious base for extending the social standing of alternative medicine.

In Russia, leading figures of the Ministry of Health of Russian Federation have insisted that alternative practitioners used double blind trials to shed light on the alien philosophies and mode of operandi of alternative practice. As in other industrialised countries, the randomised blind trial method has been the main tool used to establish the effectiveness of medical therapies. Alternative practitioners, however, have thrown into focus an issue of how central the randomised controlled trial should be. They have claimed that alternative therapies are often rooted in methodological assumptions incommensurable with biomedicine, and alternative medical approaches require research with a greater emphasis placed on qualitative outcomes (Korsun interview 2003). However, resources allocated to research in alternative medicine are inadequate, and methodological disputes over the best research strategies remain unresolved.



As regards the situation in Britain, the social standing of alternative medicine has improved, not least in the wake of the House of Lords Select Committee on Science and Technology (2000) that reported positively on alternative medicine by recommending that more systematic research be undertaken (Saks 2003a). As a result of its recommendations a Department of Health Capacity Building Group for Complementary and Alternative Medicine has been formed to promote centres of excellence in this area. A growing number of small scale trials have also been conducted which suggest that certain alternative therapies may be more effective than placebos, and indeed than some mainstream orthodox remedies (see, amongst others, Meade *et al.* 1990) – even if it is important to place the limitations of such results firmly in perspective (see Ernst *et al.* 2000). Moreover, there have been selective inputs of alternative medicine on undergraduate medical and other health professional courses (Fulder 1996; Morgan *et al.* 1998). In this respect, it has been critical that alternative therapies in Britain have received growing political support, highlighted by the activities of the all-party Parliamentary Group for Alternative and Complementary Medicine and the lobbying undertaken by Prince Charles in this field (Saks 1999a). Russia, however, still has further to go in advancing the alternative medicine field – although there have been changes in orthodox thinking on this subject.

#### **4. The attitudes of orthodox practitioner to alternative medicine**

This section is devoted to an analysis of the social position of alternative medicine inside the profession undertaken within the INTAS-based research *Russian Doctors: Social Attitudes and Strategies for Adaptation* in 2001, which *inter alia* aimed to understand the process of integration of orthodox and alternative approaches within the state sector. The analysis is based on the following questions: whether orthodox practitioners practised some alternative therapies as a sideline, what therapies were the most popular among them and why; what they thought about the wider integration of alternative medicine into the state sector; and whether and under what circumstances doctors referred their patients to alternative practitioners. The author also drew on some statistical data from the Ministry of Health of the Russian Federation.

#### **4.1. Alternative medicine in the hands of orthodox practitioners**

According to the Ministry of Health data (Karpeev and Kiseleva 2002), today there are three current types of involvement of medically-qualified practitioners in alternative practice:

- (1) full-time state employment, where medically qualified practitioners are exclusively engaged in alternative practice within the state sector and are no longer involved in orthodox biomedical practice;
- (2) part-time state employment, where medically qualified practitioners use alternative medicine as a sideline to their orthodox biomedical practice;
- (3) private practice, where medically qualified practitioners leave the state sector for private alternative practice.

In the INTAS research on 605 Russian doctors, only the second type of medical practitioners was found, those who used alternative medicine as a part-time activity. Full-time alternative practitioners, working in the state and private sectors, did not fall into the purposive sample of orthodox doctors. The analysis of the social standing of full-time alternative doctors will be given in Chapter VII, which presents the results of the qualitative research conducted by the author. The following chapter also provides an analysis of the social position of legal lay alternative practitioners, specialising in 'folk healing'.

The INTAS study found that about half of doctors (51%) practised some alternative therapies. Of those surveyed 30% used alternative therapies always or often, and 70% seldom and rarely. 14% of the doctors considered alternative therapies to be an integral part of their practice and said that they always used them alongside biomedical techniques. About half (46%) thought that their orthodox colleagues also used alternative therapies in their day-to-day practice. Some of these part-time alternative medical practitioners managed to negotiate a change in their workload with the medical administration. In Russia, medical practitioners have to take a certain amount of patients per hour. If doctors are drawn into alternative practice, they can sometimes get permission to reduce the throughput to make their consultations longer (Samoroukov interview 2003). Given the growing significance of alternative medicine in Russian



medical practice, a profile of orthodox practitioners who used alternative medicine in the state sector was drawn up to ascertain their age, gender, and medical specialty. Drawing this profile helped to determine which groups of doctors were more inclined to practise alternative medicine than others.

**4.2. The profile of orthodox practitioners who use alternative medicine in the state sector**

The survey identified that women tend to practise alternative therapies one and a half times more often than men – with 37% of men practising alternative medicine compared to 52% of women (see Table 6.1) This data parallels the small-scale study by Sharma that showed a substantial presence of women among British alternative practitioners (Sharma 1995: 127).

**Table 6.1: Practice of alternative medicine by men and women**

		Practice of CAM (%)			Overall (%)
		Yes	No	DK	
Gender	Men	37	57	6	100
	Women	52	40	8	100

Russian general practitioners practise alternative medicine more often than medical specialists – with 52% of general practitioners using alternative medicine, as compared to only 42% of medical specialists (Table 6.2). This is similar to Britain, where such therapies have generally been taken up with greater enthusiasm by generalists than by medical specialists in the acute sector (Saks 2003a: 119). As Saks indicates, in Britain, general practitioners particularly gain from their heightened engagement in alternative medicine, which, among other things, increases their opportunities for private practice in an area where it is relatively rare. They also established further mechanisms for dealing with ‘difficult’ patients who are constantly returning with chronic conditions, about which orthodox medicine at present can do little.

**Table 6.2: Practice of alternative medicine by general practitioners and medical specialists**

		Practice of CAM (%)			Overall (%)
		Yes	No	DK	
Specialty	General practitioners	52	39	9	100
	Medical specialists	42	51	7	100

The INTAS-research did not find any significant correlation between the age of the respondents to the questionnaire, their length of service and their inclination to practise alternative medicine (see Table 6.3). In each age-group investigated, the number of those who practised alternative medicine was almost equal. The exception was the group of doctors under 30, where the number of doctors who practised alternative medicine was smaller, though the difference was minimal. Thus, alternative medicine was practised by 42% of the respondents under the age of 30, by 46% of respondents from 31 to 45, by 49% of doctors from 46 to 55, and 48% of doctors over 56 years old.

**Table 6.3: Practice of alternative medicine by doctors of different age groups**

	Practice of CAM (%)			Overall (%)
	Yes	No	DK	
Under 30	42	46	12	100
31-45	46	45	9	100
46-55	49	44	7	100
56 and over	48	46	6	100

Another interesting INTAS-research finding was that medical administrators practised alternative medicine almost as often as rank-and-file doctors did. Russian head doctors have often combined administrative work and medial practice and represent the elite of the profession. Until recently they largely maintained its adversarial position towards the medically qualified using unorthodox knowledge, to defend orthodox science. This was exemplified by their lack of desire to hire doctors practising alternative medicine (Neumivakin and Neumivakina 2001). Nonetheless, medical administrators have now increasingly taken a more incorporationist stance. Today, the number of medical administrators (46%) who used alternative medicine in their practice was almost equal to the number of rank-and-file doctors (47%) (see Table 6.4). A more supportive stance towards alternative medicine in the higher echelons of the profession has also been



documented in Britain by Saks, where growing numbers of elite doctors apply unorthodox medical knowledge in their own practice (Saks 1996: 36).

**Table 6.4: Practice of alternative medicine by medical administrators and general practitioners**

		Practice of CAM (%)			Overall (%)
		Yes	No	DK	
Administrative position	Medical administrators	46	46	8	100
	Rank-and-file doctors	47	45	8	100

### 4.3. Integration of alternative medicine into the state sector: the attitude of orthodox practitioners

#### 4.3.1. The most popular alternative therapies among orthodox practitioners

The forms of alternative medicine that are most popular vary from country to country. In France, for instance, the most widely used therapy is homoeopathy, whereas in the Netherlands it is spiritual healing and in Denmark reflexology (Fisher and Ward 1994: 107). In Britain, acupuncture, herbal medicine and healing figure most strongly (Fulder 1996). The INTAS research helped to identify the most popular alternative therapies among Russian orthodox practitioners. Medical practitioners were asked whether they ever practised the following alternative methods:

- Acupuncture (the technique whereby needles are inserted into the body at certain special zones for prevention and treating diseases and disabilities);
- Apiotherapy (the appliance of bees and products of their life activities);
- Aromatherapy (external use of essential oils from plants for massage or inhalation);
- Herbalism (the use of plants in medicinal purposes);
- Healing (the direct transmission (marshalling) of psychic energy for therapeutic purposes);
- Hirudotherapy (the appliance of leeches and products of their life activities);
- Homoeopathy (treats the symptoms of a patient with diluted microscopic doses of those remedies which create similar symptoms in the healthy);
- Naturotherapy (health enhancement techniques such as diet, breathing exercises and others).

This list included those therapies that are licensed for practice in Russia. An important omission is osteopathy, which is allowed for practice, but was not included into the INTAS research. This was because osteopaths cannot practise on a part-time basis alongside orthodox activities, and the INTAS study focused on orthodox practitioners as a target group. Thus, questionnaires could not be administered to osteopaths. Russian traditional medicine, although, could be so studied and was separated into different therapies, so that each constituent could be analysed separately. Thus, herbalism, historically the most popular therapy, could be differentiated from the less popular apiotherapy and hirudotherapy.

The INTAS questionnaire survey showed that alternative medicine in the state sector in Russia not only appeared to be increasing, but also included a wide spectrum of therapies. The most popular forms of alternative medicine among the medically-qualified were herbalism (51%), homoeopathy (28%) and acupuncture (13%). Apiotherapy (8%), hirudotherapy (7%), aromatherapy (5%), naturotherapy (4%) came next. The least popular method was healing practised by only about 3% of the surveyed medical practitioners (see Table 6.5. below). Although there are variations in the types of therapies employed, this parallels the increasing interest by doctors in alternative medicine in Britain where, for example, around 40% of general practices now provide access to one or more alternative therapy within the National Health Service, with 16% of general practitioners using alternative medicine themselves (Thomas *et al.* 1995). Earlier research of Anderson and Anderson (1987) on 222 British general practitioners found that almost a third of general practitioners (31%) claimed a working knowledge of at least one form of alternative medicine, 12% had received training and 42% wanted further training in at least one area. Of the 222 doctors in the Anderson and Anderson sample, 35% were practising some form of alternative medicine themselves.



**Table 6.5: Practice of alternative medicine by orthodox therapists**

	Region (%)			Overall (%)
	Moscow	Komi	Kirov	
Herbalism	38	64	64	51
Homoeopathy	33	23	25	28
Acupuncture	16	12	11	13
Apiotherapy	10	7	7	8
Hirudotherapy	9	5	6	7
Aromatherapy	8	3	3	5
Naturomotherapy	5	4	3	4
Healing	3	1	4	3
Other methods	3	3	3	3

The respondents could choose one and more methods. Thus the estimation is done not on the basis of the number of doctors who practise a method, but by the number of alternative therapies practised by all doctors.

As is seen from Table 6.5 above, Moscow was ahead of the provinces as far as the scope of alternative medicine practised by medically qualified practitioners was concerned. With the exception of traditional herbal practice, all the other alternative therapies were more widespread among Moscow medical practitioners than provincial ones. Thus, about a third of Moscow respondents practised homoeopathy and about a sixth practised acupuncture. The corresponding figures for the provinces were lower: only about a quarter of the provincial respondents practised homoeopathy and a tenth practised acupuncture. Hirudotherapy, naturomotherapy and aromatherapy were also more popular in Moscow than in the provinces. Herbalism was the only method more popular in the provinces than in Moscow. The percentage of doctors in the capital using herbal treatment was almost half that of the regions. This could be explained by the fact that Moscow is self-sufficient in pharmaceuticals, where most medicines could be obtained without any difficulties except for the price. In the regions, on the other hand, some types of medicine are entirely absent, while others are very expensive. Another possible related reason for the distinction is that the average income in Moscow is higher than that of the provinces.

**4.4. Further integration of alternative medicine into the state sector**

The questionnaire research showed that a sizeable proportion of orthodox practitioners had a positive attitude to alternative medicine and were ready for the wider integration of alternative therapies into the state sector, although there was a difference between the tolerance of various alternative therapies (see Table 6.6). Herbalism (75%), homoeopathy (67%) and acupuncture (57%) had the greatest number of adherents

among orthodox medical practitioners. Traditional practices of hirudotherapy (34%) and apiotherapy (26%) did not receive such an enthusiastic welcome. Respondents were least prepared to back aromatherapy (18%), healing (14%), and naturotherapy (11%).

**Table 6.6: Support of orthodox practitioners for the wider introduction of alternative therapies into the state sector**

	Region (%)			Overall (%)
	Moscow	Komi	Kirov	
Herbalism	66	80	86	75
Homoeopathy	74	58	61	67
Acupuncture	52	64	61	57
Hirudotherapy	39	30	26	34
Apiotherapy	22	30	30	26
Aromatherapy	22	11	17	18
Healing	15	13	13	14
Naturotherapy	13	9	10	11
Other methods	5	4	5	4

The respondents could choose one and more methods.

It is quite likely that such a difference between the trust in various alternative methods is explained by the fact that herbalism, homoeopathy and acupuncture are more theoretical and systematic as they had been subject to more observation and research during Soviet times. These characteristics were still important to orthodox practitioners educated to believe in the ultimate value of biomedical science and research. At the same time, the revival of therapies rooted in traditional Russian medicine such as hirudotherapy and apiotherapy and the introduction of naturotherapy and aromatherapy might seem to orthodox practitioners to be non-scientific or/and not sufficiently researched.

In Britain using a slightly different approach, Anderson and Anderson (1987) obtained similar data to that discussed above, although their British medical counterparts were more sceptical at the time the study was carried out. In analysing the views of on the efficacy of alternative therapies, they asked general practitioners if they considered each therapy to have a valid theoretical basis. Manual medicine (including osteopathy and massage) was considered valid by the most numbers of respondents (32%), acupuncture by 15%, hypnotherapy by 8%, homoeopathy by 7% and healing, in contrast, by less than 1%. This pattern may be linked as in Russia to orthodox medical interests – which



are most likely to support the incorporation of alternative therapies that are least challenging to biomedical orthodoxy in face of popular demand.

Russian orthodox practitioners who were involved in practising alternative medicine themselves were more willing to accept the further expansion of alternative medicine into the domain of state medicine. They also formed the core of the strong adherents of the integration of alternative and official medicine. Doctors who did not practise alternative therapies were more wary (see Table 6.7). For example, 88% of medical practitioners who practised alternative medicine supported the integration of herbalism into the state health sector and only 60% of those who were alien to alternative medicine.

**Table 6.7: Support for the integration of alternative medicine into the state health sector**

	Doctors who practised alternative medicine (%)	Doctors who did not practise alternative medicine (%)	Overall (%)
Herbalism	88	60	74
Homoeopathy	74	58	67
Acupuncture	65	49	57
Hirudotherapy	36	30	34
Apiotherapy	34	19	26
Aromatherapy	23	13	18
Healing	17	9	14
Naturomotherapy	13	9	11
Other methods	3	1	2
None of them	3	16	9

The respondents could choose one and more methods.

At the same time, most medical practitioners who had never used alternative medicine none the less did not think that alternative medicine should be prohibited in the state health sector. As it is shown in Table 6.7, only 16% of doctors were strongly against the idea of integration of alternative medicine into the state sector. As seen in Table 6.8 below, most respondents were opposed to healing (23%) and naturomotherapy (7%) and said that these methods should be prohibited in the state medical institutions. No more than 4% of the respondents supported the idea of banning any other alternative methods in the state sector.

**Table 6.8: Alternative therapies which should be prohibited in the state health sector**

	Region (%)			Overall (%)
	Moscow	Komi	Kirov	
Healing	21	24	24	23
Naturotherapy	5	8	8	7
Other methods	5	3	2	4
Aromatherapy	1	8	5	4
Hirudotherapy	0	6	5	3
Apiotherapy	1	2	2	2
Homoeopathy	1	2	1	1
Acupuncture	1	2	0	1
Herbalism	1	0	0	0

The respondents could choose one and more methods.

Thus, the research showed that orthodox practitioners had a positive attitude towards the wider integration of alternative medicine into the state sector, although, practitioners were divided in opinion in relation to the issue who should pay for alternative therapies. Half of the respondents to the INTAS questionnaire (52%) said that alternative therapies should be paid by the patients themselves. These doctors were in accord with the stance taken by the Ministry of Health of Russian Federation which did not include alternative medicine into the list of services which were free for patients at the point of access, with the exception of acupuncture and osteopathy (Ministry of Health 2002). On the one hand, this can be explained by a condescending approach of some doctors towards alternative medicine, as a lesser number of respondents said that consultations and treatment of orthodox practitioners should be fee-for-service within the state health (see Table 6.9 below). On the other hand, alternative services may be seen as more marketable than some orthodox services. As it is shown in Table 6.9 below, they are placed between the services of cosmetic surgeons and medical specialists, while general practitioners conclude the list. Those orthodox practitioners who practise alternative medicine privately may wish to keep an opportunity for extra income for themselves.



**Table 6.9: Forms of treatment which should be fee-for-service within the state health sector**

Consultations and treatment	Region (%)			Overall (%)
	Moscow	Komi	Kirov	
Cosmetic surgeons	73	76	77	75
Alternative practitioners	45	58	59	52
Medical specialists	41	46	47	44
Dentists	42	42	43	42
General practitioners	23	16	22	21

In summary, the data discussed above provided evidence that many medical practitioners believed that certain forms of alternative medicine were useful and effective in Russia. However, it gave little indication as to why doctors believed that these therapies were effective or whether they saw alternative practitioners as equals. These issues were addressed in the INTAS questionnaire, which shed light on referrals from medical practitioners for alternative treatment. Respondents were not asked what kind of alternative treatment they recommended or whether they referred to medically qualified practitioners or to lay alternative practitioners. What mattered most was whether orthodox practitioners trusted alternative medicine with referrals and saw it as an integral part of the health sector, with a growing convergence of orthodox and unorthodox approaches.

**4.5. Medical referrals to alternative practitioners**

Vincent and Furnham argued that nowadays the attitudes of European doctors towards alternative medicine vary widely, ‘ranging from hostility bordering on paranoia to an all-accepting embracing of alternative medicine as representing the way forward towards holistic medicine and the antidote to an all too prevalent, impersonal and ultimately life-denying high technology medicine’ (Vincent and Furnham 1998: 71). The INTAS research highlighted that while there are extreme positions, most Russian doctors adopted an intermediate stance, with a growing willingness of medical practitioners to work closely with at least some alternative practitioners. On average almost half of the orthodox practitioners (47%) from the sample of 605 doctors had referred patients for some alternative treatment.

The scope of referrals of Russian doctors was similar to the scope of referrals reported for British doctors. Wharton and Lewith, for example, found that although British general practitioners did not claim to know much about most alternative therapies, 59% believed that they were useful and over 40% referred to medical practitioners of homoeopathy and herbalism, with 28% to medical acupuncturist (Wharton and Lewith 1986). Overall, referrals to medically qualified alternative practitioners were made between 59% and 76% of British general practitioners, and only slightly fewer to lay alternative practitioners (Wharton and Lewith 1986; Anderson and Anderson 1987).

The peculiar feature of the Russian sample was that there were significant regional differences as far as the frequency of referrals was concerned. The number of referrals from orthodox practitioners of Kirov and Komi region was almost twice as high as the number of their Moscow colleagues (Table 6.10):

**Table 6.10: Referrals of patients to alternative therapists**

		Region (%)			Overall (%)
		Moscow	Komi	Kirov	
	Referred	36	55	61	47
	Did not refer	37	22	20	29
	DK	27	22	18	23
	Overall	100	100	100	100

This may be explicable in terms of the self-interests of Moscow doctors. Interests are seen in the thesis research in accordance with Saks’ neo-Weberian definition as actions that objectively enhance the position of the occupational groups concerned in relation to power, status and income – as determined by the balance of costs and benefits arising in any particular situation (Saks 1996: 26). Orthodox practitioners in Moscow had more reasons for anxiety than their provincial counterparts, as the alternative medicine market was much greater and more heterogeneous. There had been a significant blurring of the boundaries between free and fee-for-service medicine in Moscow (Shishkin 2003). The INTAS research showed that the income of more than one third of Moscow orthodox practitioners was closely connected with their number of ‘unofficial’ patients. Over a third of Moscow doctors (35%) confessed that they took on patients on an informal and unofficial basis and were offered money for their treatment. In the provinces, meanwhile, chocolates and spirits were still the most popular remuneration. As Moscow



doctors were more dependent on unofficial clients for their livelihood and operated in a more competitive marketplace, they may have been more likely to see referrals to alternative practitioners as against their interests.

#### **4.5.1. Interests of orthodox doctors who referred their patients to alternative practitioners**

As has been presented above, the INTAS research showed that 47% of orthodox practitioners from the sample were ready to refer their patients to alternative practitioners. To understand the interests of the doctors who were ready to cooperate with colleagues in alternative medicine the respondents were asked to comment under what circumstances and why they referred their patients for alternative treatment. The answers to these questions showed that those who referred the patients to alternative practitioners, irrespective of the region, could be subdivided into two subgroups: ‘adherents of alternative medicine’ (30% of the respondents) and ‘sceptics’ (7% of the respondents)<sup>25</sup>. The answers of these two groups of respondents about the reasons for their referrals to alternative practitioners are analysed below.

Only a small group of ‘adherents of alternative medicine’ considered alternative medicine to be an integral part of medical treatment. They used alternative therapies in their day-to-day practice and viewed the integration of orthodox and alternative medicine as a necessity for modern Russian health care. The most common answers within this group were the following:

‘The combined [orthodox plus alternative] treatment should become the rule for a good doctor’; ‘Alternative therapy is complementary in my day-to-day practice’; ‘I always recommend combining alternative and scientific treatment’; ‘I am for the complex integrated approach to the patient’.

The majority of respondents who fell into the category ‘adherents of alternative medicine’ were medical practitioners who mainly referred their patients to alternative medicine when orthodox biomedical treatment did not help. Such doctors conceded that official medicine could benefit from cooperation with alternative medicine in cases

- when the patients were allergic to chemical medicines;

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<sup>25</sup> Overall 47% of doctors from our sample referred to alternative practitioners, however 18% of them did not answer the open question.

- when patients had chronic diseases that were non-specific and of multi-origin (cancer was mentioned here most); and illness was at an early stage and the patients needed health enhancement rather than treatment. The most common answers about the referrals of patients with chronic illnesses were: ‘when official medicine cannot help’, ‘when I lose heart and can’t see what else could be done’, ‘when official medicine reaches a deadlock’, ‘when medicines do not work’;
- when illness was at an early-stage. The group of answers that had to do with the early-stage illness stressed that the cooperation with alternative medicine was productive when the patients needed health enhancement rather than treatment: ‘people who often fall ill need to get an idea of a healthy life style’, ‘I have no time to promote healthy habits – exercise and diet – therefore I refer for alternative therapists’, ‘early stage respiratory illnesses are much better cured with alternative medicine’.

This supports other studies (for example, Sharma 1995) that show that alternative medicine is widely used by doctors in their interests to ease their workload for problems that orthodox medicine cannot solve. This interpretation is reinforced by the doctors who were ‘sceptics’ who referred patients to alternative therapists when they were basically healthy and asked for/insisted on the referral or when they thought the patients were neurotically fond of ‘thinking up’ illnesses and visiting doctors. The most frequent answers in the group were the following:

‘I refer patients with neuroses, when patients suffer from phobias’; ‘If the patients insist on the referral. It is none of my business why he needs to go there and I can refer’; ‘I send all the neurasthenics and hysterics to the alternatives. Sometimes people with minor neurotic ailments also need to go to the alternatives’

In summary, positive changes in the relationship between orthodox and alternative medicine in Russia based on incorporation have occurred. Of the 47% of medical practitioners from the sample who referred their patients to alternative therapists, the majority had a positive attitude towards alternative medicine and considered it more than placebo. They were ready to cooperate with alternative practitioners and saw alternative medicine as helpful in the treatment of chronic illnesses and health



promotion. The incorporationist strategy of the Russian medical profession can be related to the threat to its interests posed by outsiders. As Saks comments in relation to Britain, the profession in adopting this strategy has been able to create new fields to colonise in which its members, rather than competitors, have ownership of the knowledge involved (Saks 2003a: 119). Alternative medicine gives increased opportunities for private practice to Russian doctors, even if it happens on an unofficial, informal base. At the same time, in contrast to Britain, the incorporationist strategy of Russian doctors can be explained by shortages in state medicine, where many doctors have had to turn to 'cheaper' therapies, especially in the case of more 'difficult' chronically ill patients.

#### **4.5.2. Interests of orthodox practitioners who refrained from referrals to alternative practitioners**

In the INTAS sample, 29% of the respondents claimed that they refrained from referrals to alternative practitioners. Some of them, who were similar to the 'sceptics' discussed above, also saw alternative medicine as a refuge for 'unpleasant' patients with phobias and neuroses. In the INTAS research, the open question on why orthodox practitioners refrained from referrals was mostly left unanswered. Those who commented on their answer in the questionnaire split into two groups. The first group expressed distinct hostility and second group was more loyal as follows<sup>26</sup>:

- 'Opponents of alternative medicine' those who distrusted the effectiveness and safety of alternative therapies. The 'opponents of alternative medicine' gave rather broad pejorative comments such as: 'do not trust quacks', 'they are all sorcerers and money-makers', 'they lie more than they help';
- 'Conservatives', those who had little knowledge of alternative medicine and simply did not feel like investigating it, as they felt that their biomedical knowledge was self-sufficient. The 'conservatives' were more loyal, saying that there was nothing particularly wrong with alternative medicine. They simply wanted to remain aloof and to maintain the existing status quo of biomedical knowledge. One said: 'I have not seen anyone whom they have helped, and I do not feel like investigating this', and another: 'I do not practise alternative

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<sup>26</sup> These groups were seemingly equal, though the low rate of responses to this open question prevented further quantitative analysis.

therapies, and do not plan to. I have not studied for eight years in the best medical institute for nothing’.

Some doctors could not give up their ideas about the primacy of orthodox biomedicine, as these ideas and biomedical knowledge were something that had a core meaning in their lives, and from which they earned their living. As one alternative practitioner argues: ‘All drivers know that the petrol engine became obsolete about fifty years ago, but it is still being used, as a lot of money was invested in its production and people earn their living producing it. The same thing is true of biomedicine in general and the chemical industry in particular’ (Zamarenin interview 2003)

Orthodox doctors often felt opposition towards their alternative counterparts, as the demand for alternative services was constantly growing, while orthodox medicine had lost the stable and prestigious position it had during the Soviet period. Orthodox doctors were more likely to be blamed for the deterioration of people’s health and the fall in life expectancy. To conclude, an example of rivalry that still exists between orthodox and alternative practitioners can be given. During the interview research undertaken for the thesis in 2003, one prominent alternative practitioner shared with me his earlier career, when his well-rewarded orthodox colleagues were not ready to cooperate with him, as they were afraid of being considered ‘failures’. My interviewee, an alternative practitioner, a Professor, a Doctor of Medicine, an Honoured inventor of Russia, had been employed for thirty years in the best Moscow medical research institute which dealt with space medicine. When he turned to alternative practice, he made an invention of a new type of use of ultra-violet radiation for therapeutic purposes. All he wanted was to present his innovation to medical research institutes in Moscow, where his orthodox colleagues had worked on the same problem. He was politely refused when he offered to give a lecture in a few research institutions. In only one of them did he manage to collect an audience. Having given the lecture, he received an enthusiastic welcome. However, the Director of the Research Institute told him in private that they would not make use of his invention, as they would have to close the laboratory that had worked on a similar problem for years, and fourteen doctors would be considered incompetent and would be fired.



## Conclusion

This chapter has shown that alternative medicine in Russia still occupies a marginalised social position in terms of training and research. It has also been argued that in face of growing challenge from alternative therapies, the Ministry of Health maintained the continuing dominance of biomedical authority through a strategy based on the incorporation and subordination of alternative medicine. The practice of alternative medicine in Russia, except by recognised statutorily health professionals, became illegal. From among lay practitioners, only ‘folk healers’, who had a special extraordinary gift of healing in Russian traditional medicine, were exempt from the law and were allowed to practise in the open market. Alternative therapies which had the strongest affinity with orthodox medicine, and were closer in their philosophical worldviews and the *modus operandi* to the standards of orthodox biomedicine, have received a higher standing within the state sector. However, it has been shown that alternative medicine has been considered to be a threat to orthodox medicine by those orthodox doctors who occupy higher administrative positions. For rank and file doctors, it has remained rather popular. Today, a large proportion of orthodox doctors practise alternative medicine on a part-time basis. At the grassroots level, alternative medicine gives increased opportunities for private practice and helps to combat shortages in state medicine, allowing practitioners to turn to ‘cheaper’ therapies and medicines. This has especially been the case with ‘difficult’ chronic patients. The next chapter will focus on the group of alternative practitioners.

## VII. THE PROFESSIONALISATION OF ALTERNATIVE MEDICINE IN RUSSIA IN TRANSITION: PROCESS AND PERSPECTIVES

The previous chapter was devoted to the analysis of response of the Russian state and the orthodox medical profession towards alternative approaches in medicine. It was shown that in the post-Soviet period, growing demand for alternative therapies prompted an increase in the numbers of lay alternative practitioners, who drew on indigenous medicine and borrowed alternative therapies from abroad. It was argued that from a neo-Weberian perspective the Ministry of Health claimed the continuing dominance of biomedical authority through a strategy based on the incorporation and subordination of alternative medicine. The practice of alternative medicine in Russia passed into the hands of recognised statutorily health professionals. The previous chapter also highlighted the fact that a large proportion of Russian orthodox doctors practise alternative medicine on a part-time basis, as it gives increased opportunities for private practice and helps to combat the shortages of state medicine. This chapter will consider medically-qualified alternative practitioners and lay 'folk healers'<sup>27</sup>, practising full-time. These practitioners still have a marginalised social position within the state sector, as they come across difficulties in searching for, and securing, employment and in funding research and training.

This chapter will focus on the efforts of full-time alternative practitioners to professionalise, understood as the enhancement of the scope of power, and gaining economic or cultural resources in the market place or exercising influence within the state sector, in order to achieve legally underwritten professional monopoly. The professional organisations of statutorily recognised alternative practitioners who provide their services full-time in the state or private health care sector will be brought into focus here. The first part of the chapter provides the numbers of Russian alternative practitioners and the scope of their membership in professional organisations of alternative practitioners. The second part describes the current social standing of all major professional organisations of alternative practitioners. There are no umbrella bodies, which would unite various alternative therapies in Russia, therefore professional

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<sup>27</sup> It should be reiterated that other groups of lay alternative practitioners have not been analysed, as their practice is illegal in Russia.



organisations representing the interests of the main alternative therapies allowed to practise in the country are taken as the object of the research. The third part explores what aspirations these professional organisations hold for the future and shows that there are different possible ways for professional development. The fourth part of the chapter is devoted to the specifics of different professional organisations of alternative practitioners and their plans for the future. Differences and similarities in the process of professionalisation of Russian alternative practitioners and British alternative practitioners are referred to contextually throughout the chapter.

The chapter is based on interviews with nineteen prominent alternative practitioners: heads and deputy heads of eight professional organisations and rank-and-file members of these associations, who were well renowned and known throughout the country. This interview research was undertaken in January-February 2003. Among the experts there were representatives of almost all the major Moscow and All-Russian associations located in the capital, and two interviews were undertaken with the officials of the Ministry of Health of the Russian Federation (see Appendix 3). As highlighted in the Methodology and Methods chapter, the officials of the Ministry of Health did not provide the author with sufficient information, as they did not collect statistics on the numbers of alternative practitioners in different specialties or the numbers in professional organisations of alternative practitioners. Statistics were gathered instead by interviewing representatives of professional organisations of alternative practitioners.

## **1. Alternative practitioners and their ‘professional’ bodies: estimated numbers**

### **1.1. Numbers of alternative practitioners**

The literature and data research showed that there is little concrete information on the numbers of alternative therapists practising full-time in Russia; even the Ministry of Health of Russian Federation has not tracked the growth in their numbers. To acquire approximate estimates, this author carried out an approximate survey by contacting the main professional organisations of alternative practitioners. However, a great number of specialists practise outside professional bodies, and in this case this author relied on the estimates of those interviewed in the research to say how many practitioners, they

guessed, practised in their field. The interviewees were the main specialists in their field and dealt with the preparation and certification of alternative practitioners of their therapies, thus their estimates were likely to be accurate. Some figures are given in Table 7.1 below:

**Table 7.1: Alternative practitioners in Russia**

Therapy*	Estimated total
Folk healers and naturopaths	250.000
Acupuncture	25.000
Homoeopaths	13.000
Osteopathy	10.000
Herbalists	1.500
Apiotherapists	450
Hirudotherapists	500
Approximate total	300.450

Notes: \*All columns, except ‘folk healers and naturopaths’, include only medically-qualified practitioners

Let us first consider number of alternative practitioners of different specialties. As it is shown in Table 7.1, ‘folk healers’ and naturopaths represent the biggest group of alternative practitioners. They were united into one category, as Russian naturopaths often practise, using the same with folk healers methods, namely ‘healing’ and some Russian indigenous practices, and as it will be shown later, both groups belong to the same large professional organisation. This largest group of alternative practitioners is mostly comprised of lay practitioners. All the other above mentioned groups of alternative practitioners consist of doctors, as it has been mentioned, lay practitioners are not allowed to practise these therapies (State Duma 1993a). The largest group of alternative medically-qualified practitioners is acupuncture, which numbers about 25.000 practitioners. Homoeopathy is in the second place with about 13.000 medically-qualified practitioners. Osteopathy is catching up and now is in the third place, numbering 10.000 medically-qualified practitioners. The popularity of therapies is somewhat similar to the popularity of therapies in Britain, where as Fulder claims, healing is practised by 20.000 alternative practitioners; osteopathy is practised by 3.039 practitioners; acupuncture is practised by 3.000 practitioners and homoeopathy, by 1.200 (Fulder 1996: 48). Other alternative therapies are less popular.



Overall, alternative practitioners which number about 300.450 practitioners make about 45% of the total amount of orthodox practitioners<sup>28</sup> (Bureau of Statistics 2001). This figure was somewhat comparable to the ratio of alternative practitioners to orthodox practitioners in Britain, where there were 60.000 alternative practitioners to 203.398 orthodox practitioners (Mills and Budd 2000; Allsop *et al* 2004: 13). Even though as it has been already mentioned, there is a crucial difference between Russian and British alternative practitioners. In Britain, mainly non-medically-qualified practitioners launched 'the professional project' (Reilly 1983), while in Russia, it has mostly been doctors who practised alternative medicine that were driven to professionalise. The exception is the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers whose members are predominantly lay specialists. The pathways taken by different professional organisations in Russia are discussed further below.

## **1.2. Professional bodies of alternative practitioners: numbers and breadth of membership**

Andrews argued that the organisation of alternative therapies into professional bodies was minimal at the beginning of the reforms in 1991 (Andrews 1991: 11-12). The research undertaken by this author showed that the number of associations and the breadth of membership in them have increased rapidly since then. There is no umbrella body in Russia which unites all alternative therapies together, like in Britain, the Institute for Complementary Medicine, the Council for Complementary and Alternative Medicine and the British Complementary Medical Association (Saks 2003a: 149). However, as Saks claims, even in Britain these organisations were not able successfully to bridge the divisions both within, and between, alternative therapies over the nature and scale of their professional aspirations. As later analysis will show, in Russia there is no agreement among different professional organisations on their standards and goals, as only some of them wish to claim authority along the lines of the medical profession (Karpeev interview 2003).

According to the data obtained from the participants of research, in 2003 there were at least eight large professional organisations of alternative practitioners:

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<sup>28</sup> The total amount of Russian doctors was 670.000 practitioners in 1998 ([www.gks.ru](http://www.gks.ru)).



- Three associations of osteopaths: the Moscow Professional Society of Osteopaths; the League of Professional Osteopaths; the All-Russian Medical Association of Osteopathy.
- Two homoeopathic associations: the All-Russian Homoeopathic Association; the Moscow Association of Homoeopathy.
- One society of acupuncturists: the Professional Society of Acupuncturists.
- One society of herbalists: the Society of Medical Herbalists.
- One society of 'folk healers' and 'naturopaths': the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers.

These associations were considered to be 'large' as each of them had about a hundred members and more, with the exception of the Society of Medical Herbalists, which at the time of research, was in the process of acquiring legal status. The prospective head of the Society, however, said that about a hundred medically-qualified herbalists were ready to become members of this association. The largest among the above mentioned associations were the following:

- (1) The All-Russian Homoeopathic Association (about 2.500 members),
- (2) The All-Russian Medical Association of Osteopathy (about 2.000 members),
- (3) The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers (about 1.700 members). As far as professional organisations of other alternative therapies were concerned, they were very small.

The research showed that there were quite a few professional societies of apiotherapists and hirudotherapists, who did not want to enter the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers, as they did not want to be associated with 'healing' of lay non-medically-qualified practitioners. A few interviewees, a hirudotherapist and two apiotherapists, pointed out that some of their colleagues entered the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers and even learned some 'healing' techniques, like transmitting energy for therapeutic purposes. However, some medically-qualified apiotherapists and hirudologists remained outside. The number of members in professional societies of medically-qualified apiotherapists and hirudotherapists, however, did not exceed a couple of dozen. In 2002, there was an attempt on the part of hirudotherapists to unite small professional societies into an All-Russian professional



association. The congress of hirudotherapists was devoted to the celebration of the 65<sup>th</sup> anniversary of the production of medicinal leeches into the country. It came to the conclusion that there was a need for the formation of the All-Russian professional association which would unite physician-hirudotherapists, producers of medicinal leech and scientists. The participants even thought out a name for the future association – the International Collegium of Experts in Application of Medicinal Leeches. However, by 2004, this International Collegium still was not formed (Gerashenko and Nikonov 2004: 250). In summary, as the interview research showed, professional organisations of alternative practitioners were not at an equal stage in the professionalisation process.

## **2. Current social standing of alternative practitioners and their professional organisations**

### **2.1. Social standing of alternative practitioners**

As was discussed in the previous chapter, the differing social standing of various alternative therapies can be mainly explained by the ‘professionalisation from above’ that occurred in the mid-1990s. In 1996, the Ministry of Health demanded all alternative therapists produce evidence that their therapy was worth state registration, and consequently only a few alternative therapies were awarded registration. The prerequisites for state registration were a well-developed theoretical knowledge base, and a formalised system of training and developed standards for practice (Kiseleva *et al.* 2000: 12). Some of those interviewed said that two factors played an important role in the process of acknowledgment of the knowledge-base of alternative therapies by the Ministry of Health: the level of sophistication of a therapy, and whether practitioners could translate their knowledge-base into the language of orthodox medicine. Not all alternative specialties managed to claim that they were based on systematic knowledge-systems. The situation could be compared to the British one, where only two alternative therapies, osteopathy and chiropractic, succeeded in obtaining the right to state registration after convincing the medical profession that their knowledge was modelled along the lines of medical science (Cant and Sharma 1996a).

The majority of participants of the research said that individual alternative practitioners, who could be termed ‘enthusiasts’, played the most important role in proving the



theoretical base of their knowledge and translating their main medicinal and philosophical concepts into the language of biomedicine and science. The most successful appeared to be the acupuncturists, the osteopaths and the homoeopaths. As was highlighted in earlier chapters, these therapies had quite a long history of development under the patronage of the Ministry of Health, and were almost exclusively practised and researched by alternative practitioners who were mainly medically-qualified. Acupuncture and osteopathy received the highest standing among alternative therapies, as they were included into the State Nomenclature of Doctors and Pharmacists' Specialties as separate specialties (Ministry of Health 1997). This did not give these practitioners the fully enfranchised standing of orthodox medicine in the state sector, however, they received limited privileges: the right to open consulting rooms for osteopaths and acupuncturists in the state medical institutions and the provision of services free at the point of access for some categories of patients via reimbursement through the medical insurance system (Ministry of Health 2002). Homoeopathy was not included in the State Nomenclature of Doctors and Pharmacists' Specialties; however, the Ministry of Health helped to develop the system of post-qualification training in homoeopathy throughout Russia. Ministerial authorities had also encouraged the introduction of education in acupuncture, osteopathy and homoeopathy at the post-qualification level, promoted some research into them and encouraged heads of state medical institutions to employ alternative practitioners of these therapies.

At the less developed end of the professionalisation continuum were the indigenous traditional Russian therapies – herbalism, apiotherapy, hirudotherapy, and healing. Interviewees related to these therapies said that they encountered more difficulties, as these therapies were mainly in the hands of lay practitioners, who could not provide such a solid theoretical basis as, for example, acupuncturists or osteopaths. As a result, these indigenous traditional Russian therapies were not on the same footing. They never received a corresponding attention from the ministerial authorities. As Kovaleva claims, though, the Ministry of Health did not dare to forbid them, as the indigenous methods had been widely used by the population and herbalism, for example, had been partly integrated into the Soviet pharmacopoeia (Kovaleva 1993: 2). As regards to 'healing' (energy transmitting for therapeutic purposes), it had more difficulties than other indigenous Russian therapies in translating its concepts into the language of biomedicine. It was not, however, forbidden, as it had a strong lobby in the State Duma at the time (Galperin interview 2003).



It is worth noting that minor therapies such as massage, aromatherapy, diet and mineralotherapy did not produce any developed theoretical knowledge-base, but they were included in the range of state registered therapies. This may have been because they had been partly practised in the Soviet time and were conceived of as complementary to orthodox medicine (Kiseleva *et al.* 2000: 47). In contrast, Indo-Tibetan and Indian Ayurvedic therapies practised in Russia were forbidden by the Ministry of Health, even though they had a unique theoretical knowledge-base (Ministry of Health 1998). The rich theoretical traditions of the Eastern theories appeared to be 'incompatible' with orthodox medicine, as they originated and developed on the basis of various religious and philosophical concepts of far-Eastern cultures, and were practised in Russia mostly by lay practitioners, who knew well their own systems of knowledge and did not know enough of biomedicine (Zilov 1997). Indo-Tibetan alternative practitioners largely relied on Buddhism, and Ayurvedic medicine – on the basis of the oldest philosophical systems of India (Dashieva and Nikolaeva 1988; Kushnirenko 1999). In summary, it could be that different alternative therapies obtained different social standing, as a result of the actions of the Ministry of Health itself, as a consequence of dominant cultural and social views (see, amongst others, Figes 2003), and resulted in differences in the social position of professional organisations.

## **2.2. Social standing of professional organisations of alternative practitioners**

By the mid-1990s, prominent alternative practitioners managed to prove that their therapies had a developed theoretical knowledge-base. These practitioners stirred rank-and-file doctors to greater activity by involving them in the work of professional organisations of alternative practitioners. Conferences and scientific discussions held by these associations helped to work out the final shape of standards for practice and education, which were accepted by the Ministry of Health (Ministry of Health 1998). Professional organisations of alternative practitioners, however, did not receive the right to act as registering body. Some associations, as it will be shown later, hold voluntary registers, membership of which is considered a badge of honour. Official registration is in the hands of state accreditation bodies, where representatives of professional organisations only have an advisory role. Thus, all Russian professional organisations of alternative practitioners, except the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers, do not act as qualifying associations. This is similar to most professional associations of alternative practitioners



in Britain, which also act on a voluntary basis, with a caveat that British alternative practitioners do not have to undergo official registration by the state (Allsop *et al.* 2004).

The majority of Russian professional organisations of alternative practitioners have not implemented any codes of ethics and discipline, largely because as medically-qualified practitioners, they have already taken the Hippocratic Oath. The formation of the group ideology and a concern for a good public image is an important constituent of the work of these professional organisations. Among other social researchers, Freidson has emphasised that professional occupations surround their work with an ideological covering (Freidson 1994). Professionals try to assure that the wider public believe that they control their members by various means, the most popular in the West being the regular updating of an ethical code relating to professional practice (Stone 2002). In Russia, where most alternative practitioners are qualified doctors, professional associations now take steps to ensure that members adhere to the ideal of the Hippocratic Oath in their day-to-day practice.

The social standing of British professional organisations is different, as almost all alternative practitioners have put in place a unified code of discipline, education and ethics, to which most practitioners subscribe, and have self-regulatory arrangements (Saks 2003a: 149-50). In the field of acupuncture, for example, non-medical acupuncturists have self-regulatory arrangements on a voluntary basis, where the British Acupuncture Accreditation Board established minimum educational standards, and the British Acupuncture Council acts as the registering body. In the case of homoeopathy, the Society of Homoeopaths has acted as the primary focus for the professionalisation of the medically unqualified. The Society similarly established a voluntary register and laid down a code of ethics. Many homoeopathic colleagues have now been accredited by the Society (Saks 2003a: 149-50), which is again different from Russia, where all courses in alternative practices require the official accreditation of the Ministry of Health (Kiseleva *et al.* 2000: 47). In the case of British osteopathy and chiropractic, their statutory councils, the General Osteopathic Council and the General Chiropractic Council, provide for state registration and give statutory protection of title for osteopaths and chiropractors (Allsop *et al.* 2004). Although there are limits to the legal monopoly gained, there are still real restrictions on the funding on which the new professions can draw, and they do not have a privileged access to practice in the



National Health Service, as for more orthodox health professions (Saks 2003a: 150). This unites British alternative practitioners with Russian alternative practitioners, who are also still discriminated against in terms of research and are not represented in the curriculum of medical colleges.

As was discussed in the previous chapter, professionalisation tendencies of alternative practitioners in different countries may be prompted by different forces, although they have similar goals. As this author's interviews showed, alternative practitioners strive to cast off the stigmatising labels of the past. This is similar to the situation in Britain where there is also a tendency towards professionalisation (Saks 2003a: 148). Moreover, as Saks claims from a neo-Weberian perspective, professionalisation is attractive for alternative practitioners cross-culturally 'in terms of its more general potential to enhance income, status and power, as orthodox medicine has illustrated' (Saks 2003a: 149). The formation of professional organisations of alternative practitioners in both Russia and Britain may be seen as the main step taken by professionalising practitioners in the pursuit of status enhancement. The professionalisation process mainly involves 'political associations' (Field 1957: 47) that seek to regulate the members of professions, to examine and certify them or 'trade-union types of associations' (Burrage 1990) that negotiate on behalf of their members. As the following analysis will show, the above-mentioned eight large Russian professional organisations of alternative practitioners can be defined as 'political', using Field's terminology, as they aim at dealing with a balance of power in the society – being concerned with the position, the status, and the power of an occupational professional body. Burrage defines this type of association as a 'representative association', primarily seeking to lobby on behalf of a group and to obtain some legislative relief or support (Burrage 1990: 201).

Smaller associations of hirudotherapists and apiotherapists, following Field, can be defined as 'technical'. They centre on the strictly technical aspects of the occupations: the dissemination of knowledge, the exchange of information and the promotion of research, investigation and experimentation (Field 1957: 48). In the Burrage classification, they would fall into the group of 'learned societies', organisations that give prime emphasis to the knowledge-base of a group, the discussion circle, scientific society or academy (Burrage 1990: 201). In reality, these types of organisations may



shift from one priority to another, and in any case these terms could be said to be Anglo-American centric.

### **3. Professional associations of alternative medicine: a diversity of goals**

The interviews showed what was distinctive about the current period of alternative professional associations was the extent of interest in professionalising. Only representatives of indigenous traditional Russian therapies such as hirudotherapy, apiotherapy and minor therapies such as aromatherapy and hydrotherapy did not openly manifest their desire to professionalise. Some heads of professional organisations stated that although not all alternative practitioners at a grassroots level believed that professionalisation was desirable, almost all alternative practitioners were interested in strengthening their social position, gaining greater legitimacy within the state health sector and in the market. Two participants of the research commented as follows:

‘We need a stable legal status for alternative medicine in general. Then I would not have to dash against the rock, proving that we are not charlatans. I realise that I will not be respected the way I was when I worked as an orthodox doctor in a prestigious clinic. The Society, however, tries to do our best to change the situation, so that orthodox practitioners would no longer look down on us’. (The Society of Medical Herbalists)

‘In the Soviet period the Ministry of Health was all-mighty, and now professional organisations should share the responsibilities with it. Ministerial authorities have pulled over the responsibilities of accreditation and licensing, as they want to earn money from it, although they do not have a required expertise. I wish all legal procedures dealing with alternative medicine to be reconsidered’. (The League of Professional Osteopaths)

Similar to Russian orthodox practitioners, heads of professional organisations of alternative practitioners considered two options for enhancing the social standing of their professional group. First, ‘professionalisation from above’ by the state (McClelland 1990), where the leaders of professional associations were ready to give up the idea of professional autonomy in favour of the fully-fledged status of the profession, equal to that of orthodox practitioners within the state health sector. Second, some of the professional organisations of alternative practitioners considered



‘professionalisation from within’ (McClelland 1990), here the aim was the independent development of alternative medicine through a legal monopoly in the market. In this case, professional associations would have the power to determine training standards; requirements for certification and licensure; and the licensing procedures themselves. This is similar to the classical model of professionalisation of the British medical profession which acquired the relative autonomy to exercise social closure and determine the standards for practice and training in the mid-nineteenth century.

The interviews showed that different Russian professional organisations of alternative practitioners were ready to follow one or other strategy of full integration into the state sector or relative independence from the state based on a legal monopoly in the market. There was no unanimity among the members of alternative professional associations about which model was preferable. Overall, the research showed that the following associations preferred the way of ‘professionalisation from above’:

- The League of Professional Osteopaths; The All-Russian Medical Association of Osteopathy.
- The Professional Society of Acupuncturists.
- The Society of Medical Herbalists.
- The All-Russian Homoeopathic Association.

The heads and prominent members of these professional organisations of alternative practitioners said that they would prefer full integration into the state sector on the grounds that this would reduce the difference in the social standing between themselves and orthodox practitioners:

‘We are so deeply rooted in biomedicine, that it is rather a coincidence or self-interests of some ministerial authorities that we are included into the category of ‘alternative medicine. This must be changed’. (The All-Russian Medical Association of Osteopathy)

‘The Society of Herbalists was formed with the purpose to resolve the problem of further introduction of herbalism into the state sector, and the specification of the place and role of this therapy in there’. (The Society of Medical Herbalists)

‘I would do everything in my power, so that acupuncture would occupy a fitting place within the state sector and my goal will be reached only when the specialty of acupuncturist is conceived to be equal to the specialty of a family doctor’.  
(The Professional Society of Acupuncturists)

Interviewees from the Professional Society of Acupuncturists and from two associations of osteopathy, the League of Professional Osteopaths and the All-Russian Medical Association of Osteopathy, argued that further integration of acupuncture and osteopathy into the state sector could be achieved on the grounds that these approaches were as much related to orthodox scientific medicine as they were related to alternative medicine. They argued that dozens of Candidate and Doctors’ theses of medicine had been defended, although in fact, the Higher Accreditation Committee still has not included acupuncture and osteopathy into the list of therapies on which post-doctoral degree theses can be defended. Osteopaths, however, usually defend theses in related orthodox specialties, such as ‘neurology’, ‘orthopaedics’ or ‘traumatology’. Acupuncturists have received the right to defend theses in ‘neurology’. The head of the Professional Society of Acupuncturists, for example, had supervised nine theses related to issues of acupuncture for a Doctor of Medicine degree. Moreover, in 2003, the Ministry of Health cancelled financial sponsorship of 120 journals in orthodox medicine, and only 60 medical journals did not suffer any cut in financial allocation, including the journal of the League of Professional Osteopaths ‘Manual Medicine’ and the Professional Society of Acupuncturists ‘Reflexotherapy’ (Vasilenko interview 2003; Sitel interview 2003). The heads of these associations took this as an indication that osteopathy and acupuncture occupied a fitting place in the ranks of orthodox specialties as their journals received state financing on a par with journals of their orthodox counterparts.

Not all professional associations of alternative practitioners aspired to full integration into the state sector. On the contrary, heads of a few professional organisations of alternative practitioners said that they would rather follow in the footsteps of the Western professional organisations of medical practitioners, acquiring relative independence from the state based on the right to self-regulation, primarily for accreditation. The interview research showed that the following associations preferred the way of ‘professionalisation from within’:

- The Moscow Professional Society of Osteopaths.



- The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers.
- The Moscow Association of Homoeopathy.

Those interviewed from these associations commented on their plans for the future as follows:

‘I am a rationalist. I understand that it is impossible to talk about self-regulation and accreditation coming into the hands of our association right now. Nonetheless, it would be better for patients, as we are better qualified to assess the level of potential practitioners than ministerial authorities are’. (The Moscow Professional Society of Osteopaths)

‘Our association has done a lot. We keep a register of honour, we have a code of ethics, and we have experts of the highest qualification. We don’t need any supervision of the Ministry of Health’. (The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers)

‘I think there should be a compromise. I can give you an example of the Moscow Bar, which separated the functions of certification, confirmation of the skills and knowledge, and licensing, issuing of a legal assurance to practise. The Moscow Bar certifies specialists and the Ministry of Justice issues a license. Now we are preoccupied with talking over similar arrangements with the Ministry of Health. We need to get more freedom for decisions’. (The Moscow Association of Homoeopathy)

Plans for the future of the major professional Russian professional associations in alternative medicine are summarised in Table 7.2 below:

**Table 7.2 Professionalisation perspectives of professional associations of alternative practitioners**

Professionalisation from above: incorporation into orthodox state medicine	Professionalisation from within: legal monopoly in the market	Non-professionalising: do not aim to redefine their social standing
The Professional Society of Acupuncturists	The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers.	Apiotherapists
The League of Professional Osteopaths; The All-Russian Medical Association of Osteopathy.	The Moscow Professional Society of Osteopaths.	Hirudotherapists
The All-Russian Homoeopathic Association	The Moscow Association of Homoeopathy	Minor therapies: hydrotherapy, massage, etc.
The Society of Medical Herbalists		

**4. Professionalisation from above: main steps**

As shown in Table 7.2, ‘professionalisation from above’ was seen as preferable by some associations, including those of acupuncturists, osteopaths, herbalists, and homoeopaths. At the time of research, all these associations had definite plans for their future work and their plans for professionalisation in many respects overlapped. These professional associations will be considered together, as they are preoccupied with similar issues. Differences will be pointed out where they are relevant. This interview research showed that the main issue on the agenda of these organisations is that they wish to be excluded from the Ministry of Health’s category ‘alternative medicine’. Indeed, as far as medical herbalists and homoeopaths are concerned, they want to enter the State Nomenclature of Doctors and Pharmacists’ Specialties, as they believe that these measures may bring the full-fledged status of orthodox profession in terms of employment, payment and status. And if the Ministry of Health does not accept their proposal for exclusion from the category of ‘alternative medicine’, these alternative practitioners want to share the control over entry into their profession (accreditation and licensing) and control over



exit from the profession (tighter punishments for those who do not follow the standards of education and practice). This is discussed further below.

#### **4.1. Exclusion from the category ‘alternative medicine’**

The interviews showed that five alternative professional associations – the Professional Society of Acupuncturists; the League of Professional Osteopaths; the All-Russian Medical Association of Osteopathy; the All-Russian Homoeopathic Association; the Society of Medical Herbalists – were all concerned with the issue whether they should remain included in the category of ‘alternative medicine’. Osteopaths and acupuncturists especially find themselves in an ambiguous position. On the one hand, they were officially ranked as part of orthodox medicine, as they were included in the State Nomenclature of Doctors and Pharmacists’ Specialties, and, on the other hand, they had not been excluded from the Ministry of Health’s category of ‘alternative medicine’ (Ministry of Health 1998). As a result, acupuncturists and osteopaths had a foot in two camps. Within the scheme of orthodox medicine, acupuncture was related to neurology, while osteopathy was classified as related to neurology, traumatology and orthopaedics. At the same time, the therapists were formally subordinated to the Department of the Ministry of Health which deals with alternative medicine, and were the subject of control by a medical official, whose administrative position was entitled ‘Main Specialist of Alternative Medicine’. Thus, acupuncturists and osteopaths still encountered the same problems of access to practise in state medical institutions and restrictions on the funding on which they can draw, in a similar way to other alternative practitioners.

The social position of medical herbalism and homoeopathy was worse than that of acupuncture and osteopathy, as these practitioners wanted to be included into the State Nomenclature of Doctors and Pharmacists’ Specialties, but were not. The head of the Society of Medical Herbalists said that their primary goal was to be equated to the orthodox practitioners’ specialties. They wanted a legal definition of the place that the specialty would occupy within the hierarchy of the state health sector; to implement courses of herbalism in graduate medical schools and to specify the number of practitioners that should be prepared each year for examination (or to set the proportion of herbalists per 1.000 population). In this way, herbalism would become an integral part of the medical higher institution curriculum. In interview, the head of the Society



referred to the Ukrainian experience, where the Council for Non-Traditional and Folk Medicine was founded as an independent department of the Ministry of Health of Ukraine. This Council issued the Decree that the state should be responsible for the preparation of one herbalist per 30.000 of population (Korsun interview 2003). Although this figure did not seem to be big enough, the members of the Society of Medical Herbalists believed that to achieve such a proportion would be a good start. Homoeopaths also said that the integration of their therapy into the state sector was their aim. They believed that the state would not want to lose the money that it acquired from the licensing and certification programs, and the Ministry of Health would not accept self-regulatory professional organisations, threatening its monopoly.

The heads and representatives of the above professional organisations also wanted the Ministry of Health to revise the official lists of alternative and orthodox specialties. Interviewees explained that that the possible exclusion from the category of 'alternative medicine' was preferable, as it promised formalised educational programmes in higher medical institutions, wider opportunities for employment in state medical institutions, providing of alternative practitioners with the necessary equipment within the state sector, the simplification of accreditation procedures (licensure and certification) and reduced prices for obtaining licences. As interviewees from these groups argued:

'Alternative practitioners still come across more difficulties when they need to get a licence. The license does not cost much, but all procedures are time-consuming. Sometimes we have to pay ten times more unofficially to speed the process. Our orthodox colleagues do not come across similar difficulties'. (The All-Russian Homoeopathic Association)

'If we are no longer referred to 'alternative medicine', we shall have more opportunities for training, more places for employment. I, for example, would not mind leaving my present post of a practising doctor, as I'm getting older. Instead, I would prefer to give lectures in higher medical institutions, which I cannot do now'. (The All-Russian Medical Association of Osteopathy)

'Herbalism should become the leading contender among those alternative therapies, which aspire to be officially accepted as specialties equal to orthodox medicine and excluded from the list of alternatives. Herbalism satisfies all



possible demands: has a long history, was researched, has distinct goals and means to achieve them'. (The Society of Medical Herbalists)

However, interviewees also pointed out that their exclusion from the category 'alternative medicine' might have some negative consequences. They understood that their approaches and philosophy were opposite in some respects to those of orthodox doctors. And some of them said that their greater integration into the state sector was fraught with the risks of further standardisation of their therapies at the expense of an individualistic approach. Moreover, the move towards pathological prescribing would become inevitable, and this would oust a more holistic multifunctional approach. Acupuncturists, for example, pointed out that their therapy would be used in a more limited way mostly as an analgesic explained in orthodox neurophysiological terms. The representative of the Professional Society of Acupuncturists said: 'Acupuncture has a great potential which is not claimed yet. The more it integrates into orthodox medicine, the more it will adapt to the immediate needs of the state health sector, and those are evident – using acupuncture as an analgesic'.

Nevertheless, considering all advantages and limitations, the heads of the considered professional organisations said that they would still choose to be excluded from the category of 'alternative medicine'. The head of the Professional Society of Acupuncturists, for example, said that he hoped all the advantages that traditional Chinese acupuncture gave, would remain in the practice of good medically-qualified practitioners, even if they were closely incorporated into the state health sector. The advantages of a stable position within the state sector, however, had the greatest significance. The desire of acupuncturists, medical herbalists and some osteopaths and homoeopaths to have a fully-fledged 'orthodox' status was so strong that they were ready to be included into the list of 'rehabilitation' therapies, which would equate their status with physiotherapists and radiographers (Karpeev interview 2003). Their primary aim was to struggle for a better social standing within the health sector.

#### **4.2. Control over entry and exit into the profession**

As Parkin claims, collectively conscious groups in the course of furthering their interests exclude others from their group and tend to usurp the privileges of other groups (Parkin 1979: 41). In this interview research, representatives of the professional



associations under consideration were all concerned with the fact that they were kept away from the control over entry into their profession, namely from accreditation and licensing procedures. This issue especially disturbed acupuncturists and osteopaths. In 1999, the Ministry of Health limited the number of eligibles who could aspire to train in acupuncture and osteopathy (Ministry of Health 1999). Acupuncturists and osteopaths bridled at the 1999 Decrees of the Ministry of Health which claimed that training in acupuncture could be undergone only by neurologists, while training in osteopathy only by those who had been trained in orthopaedics, neurology and traumatology (Vasilenko 2002: 3-4). Before 1999, any medically-qualified doctor was allowed to train in the therapies under question and to practise them. Since then, the potential base for recruitment into acupuncture in particular, has dramatically decreased: neurologists comprised only about 7% of the total number of the medical graduates (Vasilenko 2002: 4). As a result, a great number of alternative therapists lost their jobs. About 20.000 acupuncturists who were not neurologists were officially dismissed (Vasilenko 2002: 4). Acupuncture had been actively used for pain relief in obstetrics, and the 1999 Decree exempted obstetricians specialised in acupuncture from work unless they specialised in neurology. The situation was slightly better for osteopathy, which had a wider recruitment base.

The head of the Professional Society of Acupuncturists predicted that the number of medically-qualified acupuncturists would diminish ten fold in the near future: 'We are put in the Procrustean bed: the recruitment on the basis of one medical specialty will ruin the development of the therapy'. The restrictions on recruitment meant that any qualified doctor wishing to be an acupuncturist first needed to specialise in neurology (5 months full-time studies) and only then to specialise in acupuncture (4 months full-time course). Such a long period of training would reduce the numbers of those interested. A few factors aggravated the problem. Postgraduate studies were not free, and the physician or her/his medical institutions had to pay for them. Moreover, training courses were mostly held in Moscow and other big Russian cities, where the accommodation for trainees was very expensive. The respondents said that quite a few prospective students in therapies had to give up the idea, as their medical institutions would fire them as a result of such a long absence from work.

Respondents said that the social closure introduced by the state worked against medically-qualified doctors, while overlooking the illegal activities of lay practitioners



in acupuncture and other alternative therapies. Participants in the research said that they were concerned with the fact that the state and the Ministry of Health did not take any action to put an end to the breaking of the law by lay alternative practitioners, who officially had no right to practise. Some participants of the research claimed that although lay practitioners of these specialties were few in number, their existence was still noticeable. And lay alternative practitioners, in the eyes of their medically-qualified counterparts, ruined the image of the profession as they provided unsatisfactory services. And what annoyed medically-qualified practitioners was that lay alternative practitioners competed with them for clients. As two interviewees commented:

‘So much effort was put to stand upright in the ranks of orthodox medical practitioners that I do not want to be in the same boat with healers, masseurs and pseudo-osteopaths. Not for nothing I did my postdoctoral studies’. (The League of Professional Osteopaths)

‘The success of herbalism in the second half of the twentieth century in Russia should be attributed only to the involvement of orthodox practitioners in this sphere. Their knowledge of medicine has made the therapy trustworthy. Lay practitioners who practise herbalism for profit take advantage of the medically-qualified practitioners’. (The Society of Medical Herbalists)

Interviewees who were medically-qualified alternative therapists lamented that lay alternative practitioners were not prosecuted effectively. Practitioners of all alternative therapies were intolerant towards lay practitioners. Among the research participants only two medically-qualified doctors, who belonged to the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers, out of nineteen respondents, admitted that they did not mind practising alongside lay alternative practitioners. All the other research participants suggested that the Ministry of Health should work together with professional organisations of alternative practitioners identifying lay illegal practitioners and instituting criminal proceedings against them. This negative attitude of medically-qualified alternative practitioners towards lay alternative practitioners is well exemplified by the negative attitude of Russian osteopaths towards Western trained osteopaths, who plan to open the first college of osteopathy in the country for lay practitioners, which could be taken as an example of social closure against ideological rivals, historically like it was in the UK (Larkin 1992).



### **4.3. Social closure against ideological rivals: the case of Western osteopathy**

The osteopaths interviewed said that their expertise and the stability of their social position were challenged not only by lay osteopaths and chiropractics but also by Russian medically-qualified osteopaths trained in the West, mainly in the USA, the UK, and France. According to the interviewees, these westernised osteopaths, although small in numbers, were closer to Western alternative practitioners in terms of philosophy and their attitude towards illness and the patient than Russian osteopaths were, who had been trained by Eastern European osteopaths. In July 2002, in St-Petersburg two international congresses were held, where westernised Russian osteopaths discussed problems of research and formal educational standards (Samoroukov interview 2003). As a result of the discussion, the participants of these international congresses came to the conclusion that they would try to follow the Anglo-American system of education of alternative practitioners. It was proclaimed that osteopathy in Russia should be taught in private colleges where people with no medical education would be eligible for study. Moreover, it was stated that westernised Russian osteopaths would try to get into the State Nomenclature of Doctors and Pharmacists' Specialties as practitioners of a therapy differentiated from the Russian 'manual medicine'.

At the time of research, osteopaths who had trained in the Western method did not have a professional organisation, and some of them dissociated themselves from Russian osteopaths. However, others thought that the sphere of Russian osteopathy and Western osteopathy were compatible and became members of the All-Russian Medical Association of Osteopathy. Still professional organisations of Russian osteopaths did all they could to discredit those Russian osteopaths who had trained in the western method. They seldom let them become members of their associations and, moreover, the deputy head of the All-Russian Association of Osteopathy said that he and his colleagues did their best to explain to the authorities in the Ministry of Health that osteopaths trained in the West could not be equated with other Russian osteopaths and in no circumstances should they be included into the State Nomenclature of Doctors and Pharmacists' Specialties. Osteopaths wrote articles and argued that westernised osteopaths' claims to become a separate specialty from 'osteopathy' were contentious (Sitel 2003: 2-3). Interviewees said that the desire of westernised osteopaths to be registered as a separate specialty might infringe on their rights. As one interviewee said:



‘You will, probably, think that our ideological rivalry with westernised osteopaths is nothing but petty intrigues. It is not so. Osteopathy in Russia had its own history of development. It largely drew on orthodox biomedicine, whereas Western osteopathy was almost always concentrated in the hands of lay practitioners, who paid more attention to philosophy than to medicine. I think that we need to struggle against their approaches, as they may shake our hard won position in the medical hierarchy’. (The League of Professional Osteopaths)

Following Parkin (1979), the actions of these osteopaths striving for the exclusion of osteopaths who had trained in the West from their group and the usurpation of their privileges can be defined as the strategy of social closure. To date, social closure tactics and the desire to control entry and exit into their profession, characterise the behaviour of alternative practitioners, in a similar fashion to orthodox medical practitioners.

To summarise, it has been argued that five Russian professional organisations of alternative practitioners would prefer professionalisation from above, modelling their strategy on ideal type from the Russian orthodox medical profession. Most interviewees believed that changes in their social standing would follow if they were excluded from the Ministry of Health’s category of ‘alternative medicine’, which they found to be stigmatising. They wished to be legally equated with the orthodox medical profession. To achieve this goal these professional organisations write open letters to the Ministry of Health; have political discussions among their colleagues; and use their personal contacts in the Ministry of Health to persuade ministerial authorities to follow their views. As a research participant commented: ‘My professional association comes to a decision quickly, however, I have to go the Ministry of Health for months, until they are ready to listen to the opinion of the Association’. The representatives of these professional associations, however, were not ready to submit to all decisions of the Ministry of Health. They wished to share control over entry and exit from their profession, implementing their own social closure rules. Saks claims that the forms of market regulation and social closure involved can vary both across societies in a single profession and between professions in any particular society (Saks 1999b). The analysis in the final section will show that some professional organisations of Russian alternative practitioners are less oriented towards cooperation with the Ministry of Health and are more directed towards acquiring self-regulation and monopoly in the market.



## 5. Professionalisation from within: main steps

It has been shown in the analysis so far that a small group of Russian alternative practitioners preferred the Anglo-American type of 'professionalisation from within' (McClelland 1990). Among them there were the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers, the Moscow Professional Society of Osteopaths and the Moscow Association of Homoeopathy. Some of the research participants from these groups referred to the experience of their Western counterparts, while others were unaware of developments elsewhere. They all, however, proclaimed similar goals for their professional organisations, including a desire to get some autonomy from the Ministry of Health. One of participants from the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers called to mind a Chinese proverb: 'If you go against the current, you shall reach a source'. This proverb, he said, reflected the attitude of his professional association towards the Ministry of Health, where 'going against the current' meant open manifestation of the position of alternative practitioners. He noted that they constituted a real social force and did not need the assistance and interference of the state medical authorities as far as their education, certification and other professional issues were concerned.

Research participants from these professional organisations were primarily concerned with the process of certification and licensing, which they did not want to share with the state. They stressed that professional organisations of alternative practitioners deserved the right to become self-regulatory. Most of them were also preoccupied with the issues of educational standards and educational programmes which they said should be handed down to professional associations of alternative practitioners responsible for working out requirements for recruits into the profession, and formal educational programmes for alternative practitioners should be implemented in all higher medical institutions. Another issue, which concerned representatives of these professional organisations, had to do with prices for their services. Some of them pointed out that alternative practitioners should get the right to quote prices for their services within the self-financing departments of the state medical institutions. Currently only the managers of medical institutions fixed the prices for all fee-for-services. There were also some



differences in the plans for professionalisation of these three associations which require separate consideration and are discussed below.

### **5.1. The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers**

The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers could be considered one of the most active and successful contemporary professional societies of alternative practitioners. As was discussed in the previous chapter, only one group of lay alternative practitioners in Russia received state registration and was allowed to practise (State Duma 1993b). This was the group of 'folk healers' who could prove that they had a special gift for healing or that their knowledge in traditional medicine such as bone-setting, herbalism or hydrotherapy was inherited from their ancestors (State Duma 1993b). And only this professional organisation of alternative practitioners included both medically-qualified and lay alternative practitioners. It united 1,700 'folk healers' and naturopaths from various Russian regions. Among them there were 235 medically-qualified practitioners, six of them held Doctoral degrees in Medicine, and fourteen had PhDs, whereas 306 members had secondary medical education. The other members of the association had no medical education at all (Kiseleva *et al.* 2000: 12).

It was the only professional organisation of alternative practitioners which had managed to acquire some self-regulatory powers. According to the law, 'folk healers' had to apply for a diploma of 'folk healer' which gave them the right of legal practice (State Duma 1993b). Although the requirements for this diploma were ambiguously specified, the procedures of accreditation were regularly held by the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers. 'Folk healers' with no or little medical education had to undergo examinations set by this All-Russian association or an equivalent regional association to prove their unique abilities and were given a recommendation to the Ministry of Health (Galperin 1995: 90).

The high social standing of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers can be explained by the active social stance taken by its leaders and by the strong lobby it had in the previous State Duma. This lobby, for example, tried to pass a law about 'energo-informational well-



being of Russian population', implying that 'folk healers' should become involved in politics and make decisions on what might improve and worsen the energo-informational well-being of Russians (Galperin interview 2003). This law implied the need to open new medical institutions, polyclinics and even to implement an additional system of medical authorities, which would support and research the potential of 'healing', understood as transmitting psychic energy for therapeutic purposes. In the mid 1990s, there were a few cases when the State Duma listened to 'extra-sensory' individuals who judged which political decisions were right and which were wrong. The law on the energo-informational well-being of the population, however, was not adopted although quite a few higher level Russian politicians still believed in astrology and had personal astrologists (Zenin interview 2003). The actions undertaken by this association represent a classical model of 'professionalisation from within' and are discussed in more detail below.

#### **5.1.1. The claim for an exclusive knowledge-base**

At the end of the 1980s, healing was seen as a specific therapeutic method allied to a theory or philosophy but lacking a development of the theoretical systems that underlay, for example, acupuncture or homoeopathy (Zenin interview 2003). Russian 'folk healers' had come a long way on the road to professionalisation since then. Interviews showed that the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers claimed that 'healing' was based on a new science termed 'Eniology' (energy transmission) which was a coherent and systematic theory of the functioning of human body. The association developed formal courses of professional training in Eniology. The head of this association argued that the main postulate of the new science was the fact that alongside conventional concepts of physics – mass and energy ( $E=mc^2$ ) – there was a new phenomenon of information or energy (Galperin interview 2003). Classical physics did not take into consideration the existence of elementary particles, micro-leptons, which were the cornerstone of the work of healers. These particles filled up the ether and transmitted all kinds of energy and information (Ohatrin 1989: 1). Folk healers claimed to work with these elementary particles, as only they had extrasensory abilities to sense the subtle flows of information, in particular those that carried information about illness, and to transmit the therapeutic energy to heal. Actually, there were different theoretical schools within the field: they all took root in the unknown substances and energies, while the most



popular of all of them remained the concept of 'information' (see, amongst others, Shipov 1997).

The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers also included in its numbers a group of prominent naturopaths, specialists in Russian indigenous traditional medicine, who had created the unique systems of health promotion and health enhancement. These naturopaths also claimed that their systems were based on a coherent knowledge-base. As Halliday claims, the knowledge becomes 'a core generating trait' of professionalism (Halliday 1987: 34). Knowledge constitutes the central resource of the conventional professions, as they tend to stake their claim for privileges on their educational qualifications and 'the would-be professions' follow a similar route. Books of famous Russian naturopaths had been theoretic and esoteric, introducing a new medical philosophy (Zalmanov 1980; Anohin 1998; Neumivakin and Neumivakina 2000; 2001). Many Russian naturopaths claimed to share the ideas and theories that were popular with Russian 'folk healers'. Other principal philosophical and theoretical concepts of the naturopathy movement drew on the philosophical works of the Russian philosophers: Vernadsky, Tsiolkovsky, Fedorov, Kuprevitch and others (Shatalova interview 2003). This claim for exclusive knowledge-base was closely connected with attempts of the members of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healer to gain respect from their clients and orthodox counterparts.

### **5.1.2. Professional ideology and code of ethics**

Ideology plays an important part in the formation of the inner solidarity of professional group and in the outward positioning of the group needed for its acceptance by society (Macdonald 1995). Members of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers said in interviews that they saw the gaining of respect from the wider society as an important task. To win authority and prestige they tried to promote information about the efficacy of treatments they suggested. Most of them understood that the dissemination of articles on 'healing' and other traditional therapies in the scientific-popular journals, newspapers, and participation in TV and radio programmes was essential for building up societal trust. They said that trust in 'healing' had been seriously corrupted during the tide wave of what was termed 'quackery' in the 1980s, when many people with no knowledge of



orthodox or alternative medicine proclaimed themselves ‘folk healers’ and practised solely for the pursuit of profit.

Research participants commented that this wider promotion of their therapies encountered difficulties, as the undertakings of any alternative practitioners were seldom supported by the state. And they had to rely on the help of sponsors or to invest their own money into activities for the promotion of their alternative therapies. The only easily accessible media for folk healers and naturopaths were the popular newspapers, such as *Healer* (‘Tselebnik’), *Popular Treatment* (‘Lechebnik’), *Healthy Lifestyle* (‘Zdorovii obraz zhizni’) or popular medical journals, like *Health*. Besides spreading information about their methods and their efficacy, the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healer laid down a code of ethics, to which most practitioners subscribe, that is set out below (Galperin 1995: 91):

#### Code of Honour of the Folk Healer of Russia

I understand all the importance of the mission of folk healer in the health enhancement of the Russian population and I am ready to use the gift sent down to me and to do everything in my power to serve my fellow creatures, bring good, alleviate pains and sorrow. I shall never, under no circumstances, turn my gift into my own advantage, shall never abuse of it to do harm or to flatter my vanity. I shall never work for self-interest and out of spite. I assume obligations to uphold the honour of folk healer, I shall never demean myself and always strengthen the authority of folk healer. My credo of a genuine folk healer is the following:

- to do no harm;
- to see the patient as a spiritual brother/sister who needs help;
- to have impeccable reputation, to have clear conscience and healthy body;
- to be tolerant, open-minded, and ready to help sufferers;
- to be devoted to my mission.

Folk healers understood that the code of ethics was important for self-regulation and for ensuring that members of their association followed the ideals proclaimed by the Association’s leaders. Ethical codes are intended to ensure the competence and honour of professionals so that clients can trust the technical ability and moral probity of practitioners (Carr-Saunders and Wilson 1933: 302). Politically, a code of ethics could help ‘folk healers’ and naturopaths to gain favour in the eyes of the wider public and the state. In the domain of health professions, the presence of ethical codes has been held as providing some sort of guarantee of propriety and a sign that professional body takes its public protection role seriously (Stone 2002: 62). Thus, the existence of a professional



code of ethics is an important aspect of a larger strategy that professional bodies must adopt in order to enhance their professional standing. The impact of the code of ethics will be extended, if 'folk healers' manage to present the results of research into their therapies.

### 5.1.3. Research into 'healing'

Folk healers insisted on funding research into the special abilities of the members of their association, which were vaguely termed in the law as a 'gift'. The Ministry of Health approved the application of the association and the research was funded. It was organised by the Federal Scientific Clinical and Experimental Centre for Traditional Methods of Treatment and Diagnostics. First, a special laboratory of bio-energetics was opened under the leadership of Doctor of Biology Zenin, who researched the abilities of about 500 healers (Zenin *et al.* 1998). All the healers were given the same test: they were asked to 'charge the water': that is to change the structure of the pure water. It should be noted that in 1995, Russian scientists were granted a patent, which proved that they could measure the structure and conductivity of water on a deeper level than it had been possible previously in world practice (Zenin *et al.* 1998). The investigations of the special abilities of healers were carried out by Dr. Zenin. The majority of healers managed to change the physical and chemical properties of water, but only a handful passed the 'biological test' in which the researchers placed protozoa into the 'charged water' and observed whether it was dead or alive. To the great surprise of the healers in every second vessel, protozoa died.

The All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers was dissatisfied with the results of the research. And it proclaimed that undertaken tests could not find the difference between those healers who benefited their patients and who did not, as people could react to therapeutic energy differently, not the way the protozoa did. What they stressed was important was that many healers managed to prove that they did not pretend that they had a gift for healing, as they had managed to change the physical and chemical properties of water. The Association stopped the research, recommending its members not to participate in contentious tests with protozoa. Other research on healing was done by the neurophysiologist, Academician Krapivin and Doctor of Medicine Berestov (Berestov

2001). They had observed over 5.000 patients who have undergone healing and hypnotic treatments and argued that there was a certain complex of neuropsychological and physiological ailments provoked by healing sessions. They defined these as a separate illness and called it 'occult illness', the well-known psychiatric syndrome of Kandinsky-Klerambo (Berestov 2001: 49). Folk healers, however, denied the results of this research on the ground that Dr Berestov was a Christian orthodox, which they thought made him prejudiced against 'healing'.

As a result of the unsatisfactory cooperation with the Federal Scientific Clinical and Experimental Centre for Traditional Methods of Treatment and Diagnostics, this Association of Specialists in Traditional Medicine and Folk Healer stated that only members of the Board of the Association could estimate which recruits into their profession had a gift for healing and had a good knowledge of Eniology and who did not.

## **5.2 The Moscow Professional Society of Osteopaths and the Moscow Association of Homoeopathy**

The heads of the Moscow Professional Society of Osteopaths and the Moscow Association of Homoeopathy also insisted their professional associations must be independent from the state. These associations had an important factor in common: they united medically-qualified alternative practitioners, living in Moscow, who had the most opportunities for private practice. In Moscow, the official and unofficial (existing within the state medical institutions) medical market was much better developed, compared to the medical market in the Russian provinces (Shishkin 2003). The issue of who should be responsible for the licensure and certification of specialists was a top priority for these professional associations.

'The Ministry of Health is very awkward: it has neither human resources nor financial ones to control even orthodox medicine, to say nothing of alternative medicine. They should acknowledge that we should share the responsibilities with them' (Nechaev interview 2003).

The Moscow Professional Society of Osteopaths and the Moscow Association of Homoeopathy decided to organise an independent licensing committee to



counterbalance the Ministry of Health's licensing committee. These committees planned to hold voluntary registers. The Moscow Professional Society of Osteopaths, for example, planned to estimate the qualification level of an osteopath to guarantee his/her competence and to award a voluntary category of registration. Distinct from the Ministry of Health, osteopaths would be awarded only with the categories for 'outstanding merit'; there would be no secondary degrees. The golden diploma would be given to specialists with the highest category and the silver diploma to specialists with the lower category. This association assumed the Ministry of Health's classification of categories as a basis, although it made the requirement for recruits tighter. The major problem was that the Ministry of Health would not accept this voluntary licensing committee as its equal, and osteopaths who planned to work in the state sector would still have to go to the licensing committee of the Ministry of Health, whereas private practitioners would mainly use the licensing committee of this professional organisation.

The interviews showed that the popularisation of information on the efficacy of these alternative therapies was one of the main activities undertaken by these professional associations. The creation of ethical codes did not become common, as interviewees explained, as all members of the associations were qualified doctors who had taken the Hippocratic Oath. Other indicators of the creation of a professional ideology, however, such as creating signs of outward respectability and developing relationships with external organisations were evident (Macdonald 1995). The Moscow Professional Society of Osteopaths, for example, devoted considerable attention to developing the outward signs of belonging to a profession. It had created a professional emblem of the association, made a hymn for the association, established special certificates of honour that were awarded to the best practitioners and even mini-sculptures (the spinal cord within the Mobius band) for the best scientific work in their professional sphere. The head of the society explained that all these professional insignia were important as they helped the rank-and-file members of the association to gain a sense of belonging to a professional community and were part of a fellowship.

In summary, only three Russian professional organisations of alternative practitioners did not seek full integration into the state health care sector, instead they looked for relative independence from it. This social position has positive attractions from an interest viewpoint in terms of its more general potential to enhance income, status and



power. These Russian professional organisations of alternative practitioners drive for professional monopolies in the sense achieved by Anglo-American orthodox medical profession. In a similar way to their British counterparts, these Russian professional associations of osteopaths, homoeopaths, 'folk healers' and naturopaths have established mechanisms for voluntary self-regulation. Further, the 'folk healers' and the naturopaths have voluntarily put in place a unified code of ethics, to which most practitioners subscribe. This drive for monopoly within the market was based on these alternative practitioners' larger involvement in private practice. Changes in the social attitudes of these professional organisations and the growth of their aspirations for increased autonomy could possibly lead to the development of a professional ideology, a collegiate culture and, in the long run, a transformation in their social standing. Thus, these alternative practitioners as a group might embark on a professional project, and their corporate desire to achieve autonomy could result in their upward social mobility. Much may depend on how those who use their services rate the efficacy of treatments.

## **Conclusion**

This chapter has shown that both the number of professional associations of alternative practitioners, and their membership, have increased rapidly since the beginning of reforms. However, an umbrella body, which would unite all the alternative therapies together, has not developed in Russia as in Britain. Russian professional associations represent the interests of different groups of alternative practitioners and these have differing social standing and goals. This chapter has demonstrated that the majority of professional associations of alternative practitioners preferred 'professionalisation from above'. They also wished to exclude their associations from the category of 'alternative medicine'. They wanted to establish formalised educational programmes in higher medical institutions; wider opportunities for employment in state medical institutions; and payments for their services through the medical insurance system. A smaller group of Russian alternative practitioners preferred the Anglo-American type of 'professionalisation from within'. They were primarily concerned with gaining a legal monopoly in the market, and gaining control of the process of certification and licensing and the ability to set educational standards and educational programmes – powers that they did not want to share with the state. The implications of the research for the Russian sociology of professions and for relevant groups concerned with Russian health policy are considered in Conclusion.



## CONCLUSION

In the introduction of the thesis, it was stated that there were two main purposes. The first research problem was to explore the social and economic position of orthodox medical practitioners in contemporary Russia in order to identify the potential for professionalisation. The second problem was to explore the relationship between alternative and orthodox medical practitioners – again in terms of their professional standing and current organisation. These research problems were addressed by developing a theoretical framework based on Anglo-American theories of the professions; undertaking literature reviews of the historical background of the medical profession in Russia and carrying out empirical studies of contemporary Russian medical practitioners. The findings of the research highlight the most recent changes in the professional standing of orthodox and alternative medical practitioners in modern Russia.

It is argued that this thesis has provided an original contribution to knowledge in a number of ways. First, the Anglo-American methodology of the sociology of professions was used in Russia, where it had not been used before. Its definitions and theoretical models were adapted to the Russian context. Second, the thesis made up for the lack of research on the changes in the social standing of Russian orthodox practitioners and their potential for professionalisation at the time of current socio-economic reforms. Previous literature on professionalisation of Russian doctors was limited and dated. Third, the thesis filled a gap in the research on alternative practitioners in Russia. There has been almost no work on alternative health practitioners within Russia and on the response of orthodox medical practitioners and the state to the rise of alternative medicine. Fourth, it has provided an overview of the historical development of Russian orthodox and alternative medicine on equal terms. This has not been attempted previously.

The goal of this concluding chapter is, first, to present some key findings from the research and second, to highlight the implications of the research for the Russian sociology of professions and for relevant groups concerned with Russian health policy. Areas where further research needs to take place are also considered.

# 1. Findings from the research

## 1.1. Professionalisation of Russian doctors

The research found that Anglo-American approaches to the professions are weakly developed in relation to Russian medical practitioners to date, although they have been considered as a part of the prestigious group of ‘the intelligentsia’ in the labour force. As distinct from Western medical practitioners, Russian doctors have an inconsistent social standing. In the hierarchy of professional occupations, they have a low social position in the dimensions of income and power resources, whereas they occupy a high position in the dimension of status and cultural authority over the client.

Private medical practitioners, particularly in Moscow, have acquired greater control over the content of their work and their working conditions. They have also advanced in terms of income. However, they have not gained increased autonomy. Private doctors, in a similar way to state practitioners, still come under the supervision of the state medical authorities in the Ministry of Health who carry out all the regulation in the field of private practice, including close supervision of its financial aspects.

The research also highlighted the attitudes of medical practitioners towards the significance and necessity of professionalisation. The majority of medical practitioners, who participated in the research, were discontented with the social standing of medical profession and sought to redefine it. Most state medical practitioners strive for ‘professionalisation from above’ that is, through the action by the state. There has been a resurgence of professional associations of Russian state doctors, which, in contrast to their Western counterparts, do not seek self-regulatory powers. They aim at *sharing* particular regulatory responsibilities with the state. Although private medical practitioners are keen to achieve relative autonomy from the state, they tend to push for self-regulation, similar to the classical model of professionalisation of the Anglo-American medical profession.

As was discussed, historically in Russia the process of professionalisation of orthodox medical practitioners has been both encouraged, and hindered, by the state. In tsarist times the state provided centralised patronage – private professional associations were not essential to the process. The role of professional associations, though, should not be



minimised, as there have been historical examples when corporate groups of Russian doctors progressively strove to participate in the regulation of professional matters. However, throughout the history of the country, medical practitioners managed to acquire self-regulatory powers only once, at the beginning of the twentieth century. And the professional discretion ended within a few months as a result of the Bolshevik Revolution.

It may be argued that today in the new Russian politics, the state is likely to have the most critical influence on the perspectives of professionalisation of Russian doctors. According to the latest Decree on health regulations, a new cabinet of the Ministry of Health and Social Development<sup>29</sup> still has responsibility for all health care regulations, and the scope of professional discretion of state and private medical practitioners will remain low (Government 2004). Currently, state ministerial authorities plan to enhance the social standing of the medical profession by reducing the number of medical practitioners employed in the state health care sector by half by 2010. They presume that this will increase the efficiency of work and incidentally, the income of those doctors who retain their posts in the state sector. However, the influence of doctors on decision-making in medicine is likely to remain weak, as professional autonomy in clinical and social spheres may not necessarily increase.

## **1.2. Professionalisation of alternative practitioners**

The research showed that there is no observable Anglo-American antagonism towards alternative medicine on the part of Russian rank-and-file doctors. In contrast to Western countries, only medically qualified alternative practitioners are allowed to practise in Russia. An exception is the group of 'folk healers', lay practitioners who have a special gift in 'healing' and other traditional Russian therapies. As a consequence of the increased demand for alternative services, and due to the historical tolerance towards Russian indigenous traditional therapies, alternative medicine has become popular among Russian orthodox practitioners. They have incorporated biomedical values and scientific methods into research on alternative medicine and into educational programmes and clinical practices. However, similar to the West, the state has not granted alternative medicine the fully enfranchised standing of orthodox medicine in the

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<sup>29</sup> The Ministry of Health of Russian Federation was renamed into the Ministry of Health and Social Development of Russian Federation in 2004.



state sector. It is still discriminated against in terms of research funding and does not figure in the curriculum of medical higher institutions. Only acupuncture and osteopathy have won the right to practise within the state sector and to have some costs borne by the state, whereas all other alternative therapies carry charges.

Alternative practitioners who participated in the research, protested against their marginal position in official health care and wished to obtain a status equal to that of orthodox medical profession, although in other ways their goals differed. Most wished to integrate fully into the state health care sector on equal terms with other health professions through formalised educational programmes in higher medical institutions with wider opportunities for employment in state medical institutions. However, a small group of 'folk healers' and Moscow-based alternative practitioners, who have build up a private clientele, are no longer interested in integration into the state sector and seek relative autonomy and self-regulation. They are primarily concerned with seeking to control the process of certification and licensing and setting educational standards and educational programmes which they do not want to share with the state.

It may be argued that the future holds more prospects for such 'professionalisation from within' by Russian alternative practitioners. In contrast to Russian orthodox practitioners, the strategies adopted by the professional associations of alternative practitioners are more active. They try to enhance their 'power resources', they organise meetings for association members and actively try to contact state medical authorities to give advice on professional matters. Alternative practitioners also use the mass media to attract attention to the issues of alternative medicine and publish in their own 'professional' journals. Some associations seek to regulate members of their therapeutic community through setting examinations and awarding certificates. Some professional associations even hold voluntary registers, where membership is acquired as a result of special exams and is considered to be a badge of honour. Although, for the most part these functions remain in the hands of the state. Such developments are aided by market factors. Demand for alternative services is growing. There are also opportunities for 'professionalisation from above' of alternative medicine, through the state granting some alternative therapies the status equal to that of professions supplementary to medicine. However, these measures will not abolish the discrimination against



alternative medicine and will fall short in meeting the demands of health users, as the potential of alternative medicine is likely to be underexploited.

## **2. The implications of the thesis for theory**

The thesis has shown that Anglo-American theories of professions and professionalisation are applicable for research on professionals in Russia, although care has to be taken that differences in the structure of health care are acknowledged. The thesis drew on the Neo-Weberian tradition in order to answer the main research questions, namely to develop a model for assessing the economic and power resources of Russian orthodox and alternative medical practitioners in the past and in contemporary Russia and what effect this had on the process of professionalisation. Within this theoretical framework, the author also constructed definitions of the terms 'profession' and 'professionalisation' applicable for research in the Russian context and suitable for cross-cultural research. This theoretical approach also helped to operationalise concepts of 'power resources', 'economic resources' and 'cultural resources' of orthodox and alternative medical practitioners.

The Neo-Weberian approach proved to be helpful in conceptualising occupations based on higher specialised education as universally recognisable interest-based groups which aim at gaining control of the market through the establishment of exclusionary closure, or which aim at exercising influence within the state sector in order to achieve upward social mobility and a legally underwritten monopoly. It was shown that despite the fact that there have been important historical differences in the development of professional groups and the ways of escalation of their social standing in the Anglo-American and Russian context, professionals are similar in that they have exclusive access to scarce cognitive resources which they can sometimes translate into economic and social rewards. There has been state support for medicine in Russia but there has been little room for successful manipulation of the market as the state has controlled access to education. As a consequence, there has been an oversupply of doctors, many doctors are women and work on a part-time basis. However, some private orthodox doctors and alternative medical practitioners have been able to exploit market scarcity and they may benefit from it in the future. Others still look at state patronage and unofficial payments on the side.



The Neo-Weberian theoretical framework also proved to be useful in terms of looking at both *structure*, the social position of Russian medical practitioners in the dimensions of power, income and status and at their *strategies* oriented towards redefinition of this structural position. These strategies were conceptualised as professionalisation strategies. It was argued that a case for greater professionalisation could be demonstrated through an enhancement in the scope of power, and additional economic or cultural resources in the market or within the state sector. This could eventually lead to a drive towards a legally-underwritten professional monopoly. It was suggested that the term 'professionalisation' could be used in a cross-cultural research to describe the corporate actions of the professionals to redefine the social characteristics of the profession within Weber's dimensions of power, culture and wealth.

In the thesis, in accordance with the Neo-Weberian position, the power resources of health practitioners were seen as central to the analysis, as the scope of power resources determines the opportunities of a professional group in different social dimensions such as income, prestige, and interesting work. On the basis of theoretical literature review, it was suggested that the following resources of power were key ones: (1) the relative autonomy in making professional decisions, particularly in the sphere of diagnostics and medical treatment; (2) the influence on the scope of a professional remuneration; (3) the professional control over group entry: social closure in the market and in the system of education; (4) the professional control over group exit via the sanction mechanism; (5) the existence of a strong professional organisation as in medical associations or trade unions. Other professional resources which were important for analysis were 'economic resources', financial position of doctors and 'cultural resources' which determine status and prestige of the profession and which derive from cognitive knowledge-base of the profession.

Further, the thesis has contributed to the theoretical debates over orthodox and alternative medicine in Russia. As was discussed, there has been almost no work on alternative health professionals within Russia. To fill a gap in the research, the definitions of 'orthodox' and 'alternative' medicine suitable for cross-cultural research have been suggested in the thesis. It has also been demonstrated that alternative medicine in Russia can be analysed using a neo-Weberian theoretical approach, which is sensitive to 'political' issues such as the differential social support given to different types of medicine by the state, by other significant actors, and by consumers. Market



factors such as consumer demand for alternative therapies give particular practitioners a favourable market position and may even aid professionalisation. Although, the author has demonstrated that the politics of the state is still oriented towards marginalising alternative approaches, in contrast to a more benevolent attitude of health consumers and rank-and-file orthodox medical practitioners.

### **3. The implications of the research for policy and practice**

The research findings in the thesis have implications for policy and practice for the state medical authorities of the Ministry of Health and Social Development, which remains the only regulating body in the health care sector in terms of the professionalisation of medical practitioners and the integration of alternative medicine into the official health care sector.

#### **3.1. Orthodox medical practitioners and public policy**

Future health care reforms may lead to professionalisation of Russian medical practitioners – insofar as they may enhance the scope of their power, economic or cultural resources in the market or in the state sector. The research findings indicate that if Russian doctors exercise a larger influence within the health care sector, the medical profession as a group and patients in general may benefit from it. Most medical practitioners have been discontented with their inability to influence decision-making in health care. Some of them have become disillusioned with their profession and, particularly, with their work in the state health care sector, where doctors have had the least professional discretion. The work motivation of Russian medical practitioners could increase, if they obtained the right to determine their remuneration and to exercise greater discretion in work practice for example, the right to set their own standards and to control working conditions and clinical performance and to have greater clinical freedom at the bedside.

When doctors are satisfied with their remuneration and working conditions, their decision-making is more likely to be in the interests of their patients and wider public. Thus, for example, clinical autonomy of medical practitioners may result in changes in the system of rationing of patient attendances. Now, many doctors believe that Ministry

of Health guidelines that prescribe the number of visits often do not correspond with patient demand or with the capacity of professionals to provide health care. Patients may also benefit from the increased income of medical practitioners, as they will not have to pay them on an informal and unofficial basis. To date, these direct payments have become one of the major strategies for survival among medical practitioners and one of the major obstacles for patients in obtaining qualified medical assistance.

Some distinguished doctors, leaders of All-Russian professional associations, wish to acquire the right to participate in making policy decisions as the legitimate experts on health matters. If the state grants them an opportunity to share in the work of the Ministry of Health and Social Development and/or the Compulsory Medical Insurance Fund, they, for example, may improve the overall manpower policy in the health care sector. The Ministry of Health proclaimed that in the forthcoming reforms, half of the medical practitioners employed in the state sector will be dismissed. Many doctors disagree with this labour force politics. Representatives of the Russian Medical Associations argue that decisions on mass dismissals of doctors should be reconsidered, and that the issue of an overcrowded profession may be solved through tighter control over entry into profession, which would reduce the numbers of unsatisfactory entrants.

Thus, it has been argued that a larger participation of Russian medical practitioners in decision-making procedures may be considered advantageous to the profession and the wider public. However, if the state, hypothetically, grants the profession a legally underwritten monopoly in the market or in the state sector, it may entail negative consequences. Research suggests that medical professional associations are not yet ready to become self-regulatory for historical and cultural reasons. They lack experience in making political decisions. As was highlighted, the Russian Medical Association has already criticised the state for the weakening its control over the health sector, while the non-state mechanisms for the regulation of public health have not yet developed. For many years, the activities of professional associations have been targeted at relatively small and narrow groups of elite professionals and at particular scientific and training issues. In addition, many state medical practitioners have adhered to the notion of centralised socialised medicine and do not aspire to self-regulatory powers and upward social mobility for their group. They look to private practice and working extra hours to



enhance income, rather than seeking advancement through a collective professional project.

Nevertheless, co-operation could increase in a number of ways. Members of the Russian Medical Association, the Russian Medical Associations of Private Practitioners and other significant state and private medical associations could participate in the work of federal or local departments of the Compulsory Medical Insurance Fund and/or the Ministry of Health and Social Development as follows:

- Representatives of professional associations could share in drawing up and helping to implement the main legislative documents in the health care sector, from medical science and education to the scope of remuneration and social benefits. The ability to influence the scope of remuneration could be based on the estimations of the quantity and quality of work done and the setting in which it is done.
- Professional associations could participate in control over entry into the profession, determining training standards for medical entrants and main principles for licensing of medical practitioners and medical institutions. In addition, professionals could share with universities control over the content of examinations, the conditions and goals of training and education and the numbers of 'recruits'.
- Professionals could have greater influence on the politics of the Ministry of Health in relation to exit from the medical profession. The issue of the reduction of the state medical workforce and consequent dismissals should be discussed with the representatives of professional associations as it should arguably be a professional task to identify poorly performing doctors and if necessary, to exclude them from practice. In addition, associations should offer financial or legal assistance to their members in malpractice cases.
- Professional associations and the state medical authorities could determine conditions of work such as work plans and the pace of work and co-operate in working out quality standards. Decision-making in the sphere of diagnostics and medical treatment should be carried out mainly by professional workers themselves, rather than by functionaries of the state.
- Professional associations should ensure that the profession maintains an ethical code through adherence to the values of the Hippocratic Oath and professional

values. As far as it is practically possible, the professional association should take steps to ensure that these are followed in day-to-day practice. The state should encourage initiatives of professional associations of private medical practitioners which hold voluntary registers with information about members' successes and failures – as indicated, for example, by medical negligence cases.

Favourable terms for cooperation between professional associations and the state can be created only through an improvement in the financial position of Russian doctors. The most important problem that is unresolved is the poor economic conditions of medical practitioners. The average salary in the health sector must become higher than the average salary in industry. State budget investments into the health sector should be increased. As the experts of the Russian Medical Associations argue, the allocations to the Fund of Compulsory Health Insurance should be raised from 3.6% up to 7.2%, which would bring Russia into line with other European countries.

### **3.2 Alternative medicine and public policy**

The research suggests that the further integration of orthodox medicine and alternative medicine could bring great benefit to medical practitioners as well as health users. Alternative medicine has become popular among rank-and-file doctors. Today, about half of Russian doctors practise alternative medicine on a part-time basis. Alternative therapies are for the most part in the hands of medically-qualified practitioners and, what is more, many Russian doctors have come to non-conventional medicine from the higher ranks of medical professionals, as doctors of science, inventors and State laureates in the sphere of biomedicine. This provides unique opportunities for the smooth integration of alternative medicine into official health care. Orthodox doctors are able to translate the knowledge-base of alternative medicine into the language of biomedicine. They are also better placed to incorporate the attainments of orthodox and alternative approaches into their practice.

Increasingly, orthodox doctors acknowledge that alternative medicine is helpful in dealing with areas such as chronic illness and health promotion. In addition, alternative medicine helps to combat shortages that still exist in the official Russian health sector with less expensive remedies and technologies. Furthermore, there is a growing demand



for alternative therapies from health users dissatisfied with the shortages in the medical system since the reforms and the reductionist approach to illness. According to recent research in Russia, about a quarter of Russians have consulted with alternative therapists (Fund of Public Opinion 2002). This has been followed by increased over-the-counter sales of unorthodox remedies and increased uptake of alternative therapies on a self-help basis.

On the initiative of prominent alternative practitioners, the Ministry of Health has established the Federal Scientific Clinical and Experimental Centre for Traditional Methods of Treatment and Diagnostics. However to date, resources allocated to this Centre have been inadequate, and the work of its representatives is mostly reduced to methodological disputes and historical analyses of the development of alternative medicine. Nonetheless, this Centre has managed to organise small-scale research and to disseminate information about the efficacy of some alternative therapies. This holds some promise in developing further the integration of alternative medicine into the official health sector in Russia. The suggestions below focus on how the further integration of orthodox and alternative medicine may be achieved<sup>30</sup>:

- Similar to orthodox medicine, alternative medicine should become free at the point of access for health users through medical referral, especially for health promotion and health rehabilitation of chronically ill and handicapped people.
- The Ministry of Health and Social Development could organise an office to coordinate federal alternative medicine activities and facilitate their integration into the national health care system. A federal programme for the development of alternative medicine could be put in place.
- Orthodox health professionals could be introduced to alternative medicine in a systematic way. Training in alternative medicine should go beyond the boundaries of post-qualification level and be made available in higher medical institutions. The state should encourage the opening of private medical colleges where biomedical knowledge would be complemented by an understanding of alternative therapies.

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<sup>30</sup> They broadly parallel the report of the House of Lords Select Committee on Science and Technology (2000) in Britain on complementary and alternative medicine (Department of Health 2001).

- Research into alternative medicine could be extended with financial allocations from the government. The authoritative Russian Academy of Medical Sciences could organise a working group to research alternative medicine.
- More information about alternative medicine should be made available to the public and orthodox medical practitioners, through publicity from the Ministry of Health and Social Development.
- The Ministry of Health and Social Development, as a part of the programme of 'professionalisation from above', could initiate the development of an overarching All-Russian professional organisation of alternative practitioners which would unite practitioners of various therapies. Some regulatory functions of the Ministry of Health and Social Development could be handed over to this All-Russian professional organisation.

In summary, further opportunities for the integration of alternative medicine into the state sector are connected with widening doctors' knowledge of alternative medicine. However, the danger is that this may lead to transformation of alternative therapies into biomedical modalities rather than whole system approaches. Therefore, it may be argued that alternative practitioners should not ignore the experience of lay alternative practitioners. The familiarisation of orthodox medically-qualified alternative practitioners with lay alternative practices could be encouraged through the system of refresher courses, where foreign and Russian lay alternative practitioners could be given a chance to lecture.

#### **4. Further research**

In conclusion, the findings of the thesis and the methodologies adopted indicate that further research could be undertaken in a number of fields and could include the following:

- Research on 'professional advisors', those doctors who influence the actual substance of state policy. On the board of the Ministry of Health there are state functionaries and some medically qualified doctors. The research may be designed to identify the part they play in formulating the concrete ways by which legislation is worked out and implemented.



- There could be further research on professional associations of Russian medical practitioners. General information about the overall number of regional medical associations, their work and strategies for professionalisation, will help to make up for the lack of research on professionalisation strategies of medical practitioners to date.
- Additional research could be undertaken on alternative practitioners, who have not acquired state registration and have to practise illegally. This includes what their medical philosophies and *modus operandi* are, what social place in the hierarchy of medical practitioners they occupy and what plans they have for the future.
- Research on professional associations representing alternative practitioners could be extended into other geographical areas. The social standing of Moscow and provincial alternative practitioners may be compared more fully, as well as their strategies for adaptation to their marginal social standing. Such research could show whether provincial alternative practitioners want to move from the margins to the centre of the health care system.
- The views of officially recognised alternative practitioners on how the biomedical model and orthodox medicine traditions are reflected in their actual daily work could be investigated. This includes how far alternative therapies have been accommodated to the biomedical model and scientific methods and transformed into biomedical modalities unrelated to ancient practices.
- The methodologies adopted in the thesis could be used to assess the professional standing of alternative practitioners through a positivist methodology to generalise findings. In this research, interviews with alternative practitioners provided qualitative information only for doctors practising in Moscow. The quantitative standardised research could be extended to other Russian areas to look at regional differences and to generalise the findings of the interview survey. In contrast, quantitative research on orthodox practitioners could be strengthened by in-depth interviews in all of the regions of the research.
- Cross-cultural comparative research on the professionalisation process among medical practitioners in Russia and some Western countries could be undertaken to provide an analysis of the differences and similarities of the professionalisation process of medical practitioners and the balance of power which exists between the main key stake-holders, such as physicians, the state and the public, in these countries.

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## APPENDICES

### Appendix 1: Conference papers and publications arising from research

#### Conference papers:

Luksha, O. and Saks, M. (2004) *The Social Integration of Complementary and Alternative Medicine in Official Health Care in Russia*. Paper for the European Sociological Association Symposium: Professions, Social Inclusion and Citizenship, Lincoln, England, April.

Mansurov, V. and Luksha, O. (2004) *The Professionalisation of Russian Doctors: a Step to Construction of Civil Society*. Paper for the European Sociological Association Symposium: Professions, Social Inclusion and Citizenship, Lincoln, England, April.

Mansurov, V. and Luksha, O. (2003) *Women Medical Practitioners' Social Standing in a Russia in Transition*. Paper for the VI Conference of the European Sociological Association: Ageing Societies, New Sociology, Murcia, Spain, September.

Mansurov, V., Luksha, O., Allsop, J. and Saks, M. (2002) *The Anglo-American and Russian Sociology of Professions: Comparisons and Perspectives*. Paper for the XV International Congress of the International Sociological Association, Brisbane, Australia, August.

Mansurov, V. and Luksha, O. (2002) *Russian Sociology of Professions*. Paper for the II interim workshop for research network Sociology of professions in the European Sociological Association (ESA), Paris, France, May.

Allsop, J., Mansurov, V., Luksha, O., Saks, M., Kauppinen, K. (2001) *The Attitudes of Russian Doctors to Work and Profession in the Context of Change: the Social Standing of Doctors in a Russia in Transition*. Paper for the V Conference of the European Sociological Association: Vision and Divisions: Challenges to European Sociology, Helsinki, Finland, August.

Mansurov, V., Luksha, O., Allsop, J., Saks, M., Kauppinen, K. (2000) *Russian Physicians: Attitudes to and Strategies for Adaptation to Change*. Paper given at the VI ICCEES World Congress, Tampere, Finland, July.

Luksha, O. (2000) *Sociology of Professional Groups*. Paper given at the 1st All-Russian Congress in Sociology, St-Petersburg, Russia, June (in Russian).



## **Publications:**

Luksha, O. and Mansurov, V. (2004 forthcoming) 'Perspectives for professionalisation of Russian doctors in a reforming society', in Yadov, V (ed.) *Russia in Transition*, M.: Institute of Sociology RAN (in Russian).

Mansurov, V., Luksha, O., Allsop, J. and Saks, M. (2004) 'The Anglo-American and Russian sociology of professions: comparisons and perspectives', *Knowledge Work and Society*, 2 (2): 23-49.

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**Appendix 2: List of medical institutions in Komi from which interviewees were drawn**

Name of medical institution	Administrative position of interviewees
State Syktyvkar <sup>31</sup> Polyclinic № 1	Head doctor, two heads of departments
State Syktyvkar Policlinic №2	Head doctor, head of department
State Syktyvkar Policlinic №3	Head doctor, head of department
State Phthisiology Centre	Head doctor
Republican Hospital № 1	Head doctor, two heads of department
Syktyvkar hospital № 3	Head doctor, head of department
Ezhva <sup>32</sup> hospital № 2	Head doctor, head of department
Komi Republican Diagnostic Centre	Head of department for rehabilitation and physical culture
Centre for Non-Traditional Health Methods	Head doctor
Sanitation Centre	Head of department for laboratory research
Ministry of Health of Komi Region	Ex-Minister of Health of Komi Region, deputy Minister of Health of Komi Region

<sup>31</sup> Syktyvkar is the capital of Komi Province.  
<sup>32</sup> Ezhva is the name of one of the city districts in Syktyvkar.



### Appendix 3: List of alternative doctors, interviewees in the research in Moscow

Name of interviewee	Name of association and interviewees' position	Other positions and regalia
Deryabin Alexandr	On board of the certification committee of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers	Honoured Doctor of Russia, honoured inventor of Russia, director of the Centre 'Vivaton'
Drozdova Valentina	Member of the Professional Associations of Hirudotherapists	Honoured doctor of Komi region
Galperin Jakov, Dr., Professor	President of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers	Vice-President of the Professional League of Psychotherapists of Russia; chief editor of magazine 'Bulletin of traditional (folk) medicine of Russia'; director of medical centre Eniom.
Ivanov Vyacheslav	Member of the Professional Association of Apiotherapists	First category doctor
Karpeev Alexey, PhD	Main specialist of alternative medicine in the Ministry of Health	General director of the Federal Scientific Clinical-Experimental Centre of Traditional Methods of Treatment and Diagnosis of the Ministry of Health of Russian Federation.
Kiseleva Tatyana, Dr., Professor	On board of the Certification Committee for Alternative Practitioners in the Ministry of Health of Russian Federation.	Executive director of the Federal Scientific Clinical-Experimental Centre of Traditional Methods of Treatment and Diagnosis of the Ministry of Health of Russian Federation.
Korsun Vladimir, Dr., Professor	Head of the Society of Medical Herbalists.	Vice-director of the Institute of Phytotherapy, chief-editor of 'Practical pytotherapy'
Mologavenko Vladimir, PhD.	Member of the Society of Medical Herbalists.	First category doctor
Nechaev Alexandr, PhD	Member of the Moscow Association of Homeopathy.	

Neumivakin Ivan, Dr., Professor	On board of the certification committee of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers	Honoured inventor of Russia, laureate of the State Prize.
Samoroukov Alexei, PhD	President of the Moscow Professional Society of Osteopaths; vice-president of the All-Russian Association of Osteopathy.	Director of the Centre for Osteopathy affiliated to the Russian Scientific Centre of Rehabilitation and Balneology of the Ministry of Health.
Shatalova Galina, Dr., Professor	On board of the certification committee of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers	Honoured inventor of Russia; Honoured Doctor of Russia
Sitel Anatoly, Dr., Professor	The head of the League of Professional Osteopaths	Honoured Doctor of Russia; director of the Center of Osteopathy of the Ministry of Health of the Russian Federation
Skryabin Konstantin	Member of the League of Professional Osteopaths	First category doctor
Vasilenko Alexey, Dr., Professor	Head of the Professional Society of Acupuncturists	Chief-editor of the journal 'Reflexotherapy'; head of the Department of Acupuncture at the Medical Institute of Dentistry № 3.
Vorotnikov Vladimir, PhD	Member of the Professional Society of Acupuncturists	
Zamarenin Nikolai, PhD	President of the All-Russian Homoeopathic Association.	Vice-president of the International League for Homoeopaths
Zenin Stanislav, Dr., Professor	On board of the certification committee of the All-Russian Professional Medical Association of Specialists in Traditional Medicine and Folk Healers	Honoured Doctor of Russia
Zhohov Valentin, PhD	Member of the Professional Society of Acupuncturists	Member of the Society of Christian Orthodox Doctors



**Appendix 4 Questionnaire in the research Russian Doctors: Social Attitudes and Strategies for Adaptation**

**RUSSIAN ACADEMY OF SCIENCES  
INSTITUTE OF SOCIOLOGY**

*QUESTIONNAIRE*

**MOSCOW, 2000**

1. SEX  
Male ..... 1  
Female..... 2

2. AGE

	AGE IN YEARS
--	--------------

3. WHAT POSTGRADUATE STUDIES DID YOU UNDERGO?
- Internatura..... 1  
Ordinatura ..... 2  
Ph.D. .... 3  
Refresher courses..... 4  
I did not undergo postgraduate studies ..... 9

4. IN WHAT SPECIALTY DID YOU TRAIN? (Please indicate)\_\_\_\_\_

5. WHAT IS YOUR LENGTH OF SERVICE IN MEDICAL PRACTICE? (Please indicate)\_\_\_\_\_

6. WHAT IS YOUR SPECIALTY NOW? (Please indicate)\_\_\_\_\_

7. WHAT IS YOUR CATEGORY?
- Prime ..... 1  
First ..... 2  
Second ..... 3  
No category..... 9

8. IF YOU HAVE AN ADMINISTRATIVE POSITION, WHAT IS THIS? \_\_\_\_\_

9. ARE YOU A MEMBER OF A MEDICAL PROFESSIONAL ASSOCIATION (SOCIETY) AT PRESENT?
1. YES  
2. NO [GO TO QUESTION 11]

10. PLEASE, GIVE THE FULL NAME OF ALL THE MEDICAL ASSOCIATIONS (SOCIETIES) TO WHICH YOU BELONG

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

11. ARE YOU A MEMBER OF A TRADE UNION AT PRESENT?
- YES..... 1  
NO..... 2



II. YOUR MEDICAL INSTITUTION

12. PLEASE GIVE THE FULL NAME OF YOUR MEDICAL INSTITUTION

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13. WHAT MEDICAL INSTITUTION ARE YOU WORKING AT NOW?

- State medical institution ..... 1
- State institution with fees-for-service ..... 2
- Private institution..... 3
- Joint-stock company ..... 4
- Co-op institution ..... 5
- Foreign company ..... 6
- Joint venture..... 7
- Mixed ownership ..... 8
- Public institution..... 9
- DK..... 99

14. HOW LONG HAVE YOU WORKED AT THIS MEDICAL INSTITUTION?

- Less than 3 years..... 1
- From 3 to 5 years ..... 2
- From 6 to 10 years ..... 3
- From 11 to 15 years ..... 4
- More than 15 years ..... 5

15. IN YOUR INSTITUTION, WHICH SERVICES CARRY CHARGES?

- Medical specialists’ consultations..... 1
- General practitioners’ consultations ..... 2
- Alternative practitioners’ consultations ..... 3
- Services for inpatients (accommodation, board)..... 4
- Laboratory tests..... 5
- Additional services (separate words for patients, etc.) ..... 6
- Ward (rooms’) lease..... 7
- Advanced diagnostic tests (e.g. computer-assisted, etc.)..... 8
- Stomatology ..... 9
- Cosmetology ..... 10
- Specialist treatments ..... 11
- Other ..... 77
- Specify \_\_\_\_\_
- DK..... 88
- We do not provide services on a fee-for-service basis..... 99 [GO TO QUESTION 17]

16. IN YOUR MEDICAL INSTITUTION, APPROXIMATELY WHAT PROPORTION OF INCOME COMES FROM PRIVATE HEALTH CARE?

- Approximately about \_\_\_\_\_ %
- DK..... 000

**17. IN YOUR MEDICAL INSTITUTION, ON WHAT AREAS ARE EARNINGS FROM PRIVATE HEALTH CARE USUALLY SPENT? Please answer each line**

Expenditures	Most often	Sometimes	Never	DK
1. Technical equipment (X ray, etc)	3	2	1	9
2. Medical and routine supplies (drugs, bandages, etc )	3	2	1	9
3. Household expenditures	3	2	1	9
4. Repairs	3	2	1	9
5. Bonuses to staff	3	2	1	9
6. Other (specify) _____	3	2	1	9

**18. HOW HAS THE STATE OF AFFAIRS IN YOUR MEDICAL INSTITUTION CHANGED SINCE 1992? Please answer each line**

State of affairs	Changed for the better	Stayed the same	Changed for the worse	DK
1. Technical equipment supply	3	2	1	9
2. Maintenance of technical equipment	3	2	1	9
3. Medical and routine supplies	3	2	1	9
4. Building maintenance	3	2	1	9
5. Quality of patient care generally	3	2	1	9
6. Prevention of ill-health	3	2	1	9
7. Level of qualification of doctors	3	2	1	9
8. Opportunity for training	3	2	1	9
9. Working conditions for doctors	3	2	1	9
10. Quality control	3	2	1	9

**19. HOW HAVE THE FOLLOWING ISSUES CHANGED SINCE 1992? Please answer each line**

	Improved	Remained unchanged	Worsened	DK
1. Opportunities to use your knowledge and experience	3	2	1	9
2. Wage level	3	2	1	9
3. Relations between rank-and-file doctors and administration	3	2	1	9
4. Social security	3	2	1	9
5. Opportunities for career promotion	3	2	1	9



**20. IN YOUR INSTITUTION, WHAT IS THE INFLUENCE OF THE MEDICAL ADMINISTRATION IN THE FOLLOWING AREAS? Please, answer each line using a five-point scale, where “5” means “very great influence” and “1” means “no influence”**

	Very great influence	Great	Medium	Little	No influence	DK
1. Admittance of new doctors	5	4	3	2	1	9
2. Dismissal of doctors	5	4	3	2	1	9
3. Drawing up work plans	5	4	3	2	1	9
4. Work tempo	5	4	3	2	1	9
5. Wage levels	5	4	3	2	1	9
6. Bonuses/allowance payments	5	4	3	2	1	9
7. Medical institution funds: profit, credit, etc.	5	4	3	2	1	9
8. Control over doctors’ work quality	5	4	3	2	1	9
9. Changes in working conditions	5	4	3	2	1	9

**21. WHAT IS THE INFLUENCE OF TRADE UNIONS ON THE ISSUES SHOWN BELOW? Please, use the same scale for assessment.**

	Very great influence	Great	Medium	Little	No influence	DK
1. Admittance of new doctors	5	4	3	2	1	9
2. Dismissal of doctors	5	4	3	2	1	9
3. Drawing up work plans	5	4	3	2	1	9
4. Work tempo	5	4	3	2	1	9
5. Wage levels	5	4	3	2	1	9
6. Bonuses/allowance payments	5	4	3	2	1	9
7. Medical institution funds: profit, credit, etc.	5	4	3	2	1	9
8. Control over doctors’ work quality	5	4	3	2	1	9
9. Changes in working conditions	5	4	3	2	1	9

**22. WHAT IS THE INFLUENCE OF RANK-AND-FILE DOCTORS AT YOUR MEDICAL INSTITUTION ON THE ISSUES SHOWN BELOW? According to the same scale**

	Very great influence	Great	Medium	Little	No influence	DK
1. Admittance of new doctors	5	4	3	2	1	9
2. Dismissal of doctors	5	4	3	2	1	9
3. Drawing up work plans	5	4	3	2	1	9
4. Work tempo	5	4	3	2	1	9
5. Wage levels	5	4	3	2	1	9
6. Bonuses/allowance payments	5	4	3	2	1	9
7. Medical institution funds: profit, credit, etc.	5	4	3	2	1	9
8. Control over doctors' work quality	5	4	3	2	1	9
9. Changes in working conditions	5	4	3	2	1	9

**III. FINANCIAL STATUS**

**23. HOW IMPORTANT ARE THE FOLLOWING INCOME SOURCES FOR YOUR FAMILY? Please, answer each line.**

	Very import ant	Import ant	Some what import ant	Hardly ever import ant	Unimp ortant	DK
1. Your wages	5	4	3	2	1	9
2. Other household wages	5	4	3	2	1	9
3. Your earnings from private practice	5	4	3	2	1	9
4. Your earnings from other sources	5	4	3	2	1	9
5. Social security benefits	5	4	3	2	1	9
6. Rent from housing	5	4	3	2	1	9
7. Interest from investments/ savings	5	4	3	2	1	9
8. Savings	5	4	3	2	1	9
9. Help from relatives and friends	5	4	3	2	1	9
10. Other (specify)_____	5	4	3	2	1	9



24. HOW WOULD YOU ESTIMATE THE CURRENT FINANCIAL STATUS OF YOUR FAMILY? Please, check one

- We live from hand to mouth ..... 1
- We have enough money for food.  
We cannot afford new clothes..... 2
- We have enough money for food and clothes.  
We cannot afford expensive household things (TV set, fridge, etc.)..... 3
- We can buy most expensive household things.  
but we cannot afford a new car or a dacha ..... 4
- We do not deprive ourselves of anything.....5

IV. PROFESSION

25. HOW DID THE FOLLOWING FACTORS INFLUENCE YOUR CHOICE OF THE MEDICAL PROFESSION? Please, answer each line using a five-point scale, where “5” means “very great influence” and “1” means “no influence”

	Very great influe nce	Great	Medi um	Little	No influe nce	DK
1. Relatives’ advice	5	4	3	2	1	9
2. Mass media influence	5	4	3	2	1	9
3. Desire to help people	5	4	3	2	1	9
4. Interest in clinical practice	5	4	3	2	1	9
5. Interest in research	5	4	3	2	1	9
6. It was a calling	5	4	3	2	1	9
7. Chance (it just happened)	5	4	3	2	1	9
8. Other (please, specify)_____	5	4	3	2	1	9

26. WHERE DID YOU SPEND THE MAJOR PART OF YOUR CHILDHOOD?

- Moscow, St. Petersburg .....1
- In a megalopolis with population of a million people or more .....2
- In a big city with population of 500000 to 1 million people.....3
- In an average city with population of 200000 to 500000.....4
- In a small town with population of 10000 to 200000 .....5
- In a town-type settlement.....6
- In a village.....7

27. WHAT EDUCATION DO YOUR PARENTS HAVE? Please, specify its highest level.

EDUCATION	Mother	Father
Elementary	1	1
Incomplete secondary (9 grades)	2	2
Secondary (11 grades)	3	3
Vocational	4	4
Technical (technical school)	5	5
Incomplete university education (no less than three years of university studies)	6	6
University	7	7
Post graduate	8	8
Academic degree (Ph.D., etc.)	9	9

28. WHAT HAS BEEN THE MAIN AREA OF YOUR PARENTS' WORK?

	Mother	Father
Extractive industry	1	1
Manufacturing industry	2	2
Power engineering	3	3
Transport	4	4
Communication (e.g. post office, tele-communicatio, mobile-communication etc.)	5	5
Construction (house-building, road-building, etc.)	6	6
Agriculture	7	7
Forestry	8	8
Social security, finance, credit system	9	9
Trade (wholesale and retail)	10	10
Consumer services (e.g., laundry, repairs, etc.)	11	11
Communal-general services	12	12
Education	13	13
Health system	14	14
Science	15	15
Culture and leisure (e.g. library, cinema, etc.)	16	16
Mass media (e.g. newspaper, radio)	17	17
State and municipal organisations	18	18
Public organisations (trade-unions, etc.)	19	19
Army and law-enforcement services	20	20
Other	21	21

29. DO YOU HAVE ANY RELATIVES WHO ARE DOCTORS?

YES..... 1

NO.....2 [GO TO QUESTION 31]



**30. IF YOU DO, WHO ARE THEY?**

Father .....	1
Mother .....	2
Mother’s father .....	3
Father’s father .....	4
Mother’s mother .....	5
Father’s mother .....	6
Mother-in-law .....	7
Father-in-law .....	8
Brother .....	9
Sister .....	10
Spouse .....	11
Other relative .....	88

**31. TO WHAT EXTENT ARE YOU SATISFIED WITH YOUR WORK?**

Completely satisfied .....	5 [GO TO QUESTION 33]
Satisfied in general .....	4 [GO TO QUESTION 33]
Partially satisfied, partially dissatisfied .....	3
Unsatisfied in general .....	2
Unsatisfied .....	1
DK .....	9

**32. WITH WHICH OF THE FOLLOWING ARE YOU DISSATISFIED? Please, check one or more**

Low wages .....	1
Poor working conditions .....	2
Low quality of patient care .....	3
Nature of patients .....	4
Shortage of equipment and supplies .....	5
Inability to influence decision making .....	6
Insufficient medical staff .....	7
Insufficient support staff .....	8
Lack of career opportunities .....	9
Lack of training opportunities .....	10
Other .....	88
(Specify) _____	

**33. ARE YOU PLANNING TO LEAVE YOUR PRESENT POST?**

YES .....	1
NO .....	2
POSSIBLY .....	3

34. GIVEN THE CHOICE, WHERE WOULD YOU PREFER TO WORK? (check only one)

- State medical institution ..... 1
- State institution with fees-for-service ..... 2
- Private institution ..... 3
- Joint-stock company ..... 4
- Co-op institution ..... 5
- Foreign company ..... 6
- Joint venture..... 7
- Mixed ownership ..... 8
- Public institution ..... 9
- DK..... 99

35. WOULD YOU ADVISE YOUR CHILDREN OR OTHER CLOSE RELATIVES TO FOLLOW A CAREER IN MEDICINE?

- YES..... 1
- NO..... 2
- DK..... 9

*Please, give reasons for your answer*

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36. HOW MANY TIMES HAVE YOU TAKEN A REFRESHER COURSE SINCE 1992?

- Once ..... 1
- Twice ..... 2
- Three times ..... 3
- More than three times ..... 4
- Not at all..... 9

37. SINCE 1992, DO YOUR MEDICAL COLLEAGUES TAKE REFRESHER COURSES MORE OR LESS OFTEN? (Please, check one)

- More often..... 1[GO TO QUESTION 39]
- The same ..... 2[GO TO QUESTION 39]
- Less often..... 3

38. WHY DO YOU THINK DOCTORS DO NOT TAKE REFRESHER COURSES OFTEN ENOUGH (give reasons)

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**39. WHICH OF THE FOLLOWING STATEMENTS BEST DESCRIBES YOUR FEELINGS ABOUT YOUR WORK?**

- My work is a contract:  
the more I am paid for, the more I do ..... 1
- My work does not depend on the income I earn.  
I do all I can regardless of income ..... 2
- My work is a necessity.  
If I had money from other sources, I would not work ..... 3
- I like my job, but my family  
(household duties, hobbies) matter most to me..... 4
- I love my work: it is of ultimate value to me ..... 5
- DK..... 9

**40. DO YOU THINK THAT YOU HAVE ACHIEVED SUCCESS AS A PROFESSIONAL?**

- Yes, I have achieved ..... 1
- No, I have not, but I will achieve..... 2
- No, I have not, and I will not achieve ..... 3
- DK..... 9

**41. HOW WOULD YOU RATE THE QUALITY OF CLINICAL WORK OF YOUR MEDICAL COLLEAGUES? On this scale “10” means “high quality”, “1” means “low quality”.**

10            9            8            7            6            5            4            3            2            1

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**42. HOW WOULD YOU RATE THE QUALITY OF PATIENT CARE IN YOUR MEDICAL INSTITUTION? On this scale “10” means “high quality”, “1” means “low quality”.**

10            9            8            7            6            5            4            3            2            1

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**43. HAVE YOUR EXPECTATIONS OF A CAREER IN MEDICINE BEEN FULFILLED? (Check one)**

- Fulfilled completely ..... 4
- Fulfilled partly: the doctor’s job appeared to be easier than I expected ..... 3
- Fulfilled partly: the doctor’s job appeared to be more difficult than I expected..... 2
- Did not fulfil at all ..... 1
- DK..... 9

44. HOW OFTEN DO YOUR COLLEAGUES READ THE FOLLOWING PROFESSIONAL PERIODICALS?

	Often	Rarely	Never	DK
1. Monographs	3	2	1	9
2. Newsletters, information bulletins	3	2	1	9
3. Journals	3	2	1	9
4. Newspapers	3	2	1	9
5. Other (specify)	3	2	1	9

45. HOW MUCH DO YOU WORRY ABOUT EACH OF THE FOLLOWING AREAS?  
(please answer each line using the scale where “5” means “worry a lot”, “1” – “do not worry at all”)

	Worry a lot		Somewhat worry		Do not worry at all	DK
1. Relations within the family	5	4	3	2	1	9
2. Relations with your colleagues	5	4	3	2	1	9
3. Threat of losing your job	5	4	3	2	1	9
4. Threat of being not up-to-date in medicine	5	4	3	2	1	9
5. Financial problems	5	4	3	2	1	9
6. Health problems	5	4	3	2	1	9
7. Losing motivation	5	4	3	2	1	9
8. Lack of career opportunities	5	4	3	2	1	9
9. Feeling that your knowledge and experience are undervalued.	5	4	3	2	1	9
10. Uncertainty about the future	5	4	3	2	1	9
11. Disillusionment with your work	5	4	3	2	1	9
12. Other (specify)_____	5	4	3	2	1	9



**46. WHICH OF THE FOLLOWING PROVIDES PROTECTION FOR DOCTORS?**  
**(Check one or more)**

- Colleagues.....1
- Medical institution administration .....2
- Medical association.....3
- Trade union .....4
- Ministry of Health.....5
- Justice bodies .....6
- International organisations.....7
- There is no place to apply to: nobody cares for doctors .....8
- Other .....9
- Specify\_\_\_\_\_
- DK.....88

**47. HOW WOULD YOU RATE THE IMPORTANCE OF YOUR PRACTICE AS A DOCTOR IN YOUR LIFE WORLD?**

- Very important.....5
- Important.....4
- Somewhat important. ....3
- Hardly ever important.....2
- Unimportant.....1
- DK.....9

**Please comment on your answer**

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## V. PRIVATISATION OF MEDICINE

### 48. DO YOU SUPPORT THE PRIVATISATION OF MEDICINE?

Support completely .....	5
Support in general.....	4
Partly support.....	3
Do not support in general.....	2
Do not support at all.....	1
DK.....	9

### 49. WHAT MEDICAL SERVICES SHOULD BE PROVIDED ON A FEE-FOR-SERVICE BASIS?

Medical specialists' consultations.....	1
General practitioners' consultations .....	2
Alternative practitioners' consultations .....	3
Services for inpatients (accommodation, board).....	4
Laboratory tests.....	5
Additional services (separate words for patients, etc.) .....	6
Ward (rooms') lease.....	7
Advanced diagnostic tests (e.g. computer-assisted, etc.) .....	8
Stomatology .....	9
Cosmetology .....	10
Specialist treatments .....	11
Other .....	77
Specify .....	
DK.....	88

### 50. DO YOU THINK THAT SOME GROUPS OF THE POPULATION SHOULD BE EXEMPT FROM PAYMENT FOR TREATMENT?

YES.....	1
NO .....	2 [GO TO QUESTION 52]
DK .....	3

### 51. WHAT POPULATION GROUPS SHOULD BE EXEMPT FROM PAYING?

Children .....	1
Handicapped people.....	2
People with a chronic disease .....	3
Pensioners .....	4
Low income families .....	5
Medical workers .....	6
Large families (three children and more) .....	7
Other .....	8
(Specify) .....	
DK .....	9



52. HOW OFTEN DO PATIENTS OFFER ADDITIONAL REMUNERATION/GIFTS TO THEIR DOCTORS?

- Very often .....5
- Often .....4
- Sometimes.....3
- Rarely.....2
- Never.....1
- DK.....9

53. WHICH STATEMENT COMES CLOSER TO YOUR VIEW? (Please, check one)

1. I think that doctors in state medical institutions should get additional remuneration/gifts from patients (Give reasons for your answer)

2. I think that doctors in state medical institutions should *sometimes* get additional remuneration/gifts (Give reasons for your answer)

3. I think that doctors in state medical institutions should *never* get additional remuneration/gifts from their patients (Give reasons for your answer)

9. DK

54. HOW DID YOUR MEDICAL INSTITUTION CHANGE AFTER THE INTRODUCTION OF COMPULSORY MEDICAL INSURANCE? (Please answer each line)

	Changed for the better	Stayed the same	Changed for the worse	DK
1. Technical equipment supply	3	2	1	9
2. Medical and routine supplies	3	2	1	9
3. The level of doctors’ wages	3	2	1	9
4. The quality of patient care	3	2	1	9

55. HOW DID YOUR MEDICAL INSTITUTION CHANGE AFTER THE INTRODUCTION OF PRIVATE MEDICAL INSURANCE? (Please answer each line)

	Changed for the better	Stayed the same	Changed for the worse	DK
1. Technical equipment supply	3	2	1	9
2. Medical and routine supplies	3	2	1	9
3. The level of doctors' wage	3	2	1	9
4. The quality of patient care	3	2	1	9

VI. PROFESSIONAL ETHICS

56. IN YOUR MEDICAL PRACTICE, WHAT ARE THE MAIN SOURCES OF INFORMATION ABOUT THE ETHICAL ASPECTS OF PRACTICE?

- Course on Ethics at the University.....1
- Monographs, journal articles, etc.....2
- Knowledge of GCP (good clinical practice) .....3
- Discussions with colleagues .....4
- Other .....8
- (Please, specify)\_\_\_\_\_

57. ARE YOU AWARE OF THE GCP CODE OF ETHICAL NORMS IN MEDICINE ADOPTED IN THE EUROPEAN UNION MEMBER COUNTRIES?

- I am well aware of it ..... 1
- I have heard of it .....2
- I have never heard of it .....3

58. WITH WHOM DO YOU COMMONLY DISCUSS THE ETHICAL DILEMMAS WHICH ARISE IN PRACTICE? (check one ore more)

- Patients .....1
- Patients' relatives.....2
- Your family.....3
- Medical colleagues .....4
- Medical administrators .....5
- Medical associations .....6
- Trade unions .....7
- I do not discuss ethical dilemmas with anyone.....8
- Other .....9
- Specify\_\_\_\_\_
- DK.....88

59. IF PATIENTS ARE “DIFFICULT” (HOT-TEMPERED, “UNPLEASANT”), DO YOU...

- Pay less attention to them ..... 1
- Pay as much attention to them .....2
- Pay more attention to them .....3
- DK.....4



**60. WHAT REMUNERATIONS/GIFTS DO PATIENTS COMMONLY OFFER TO DOCTORS FOR THEIR TREATMENT? (Check one or more)**

- Flowers, spirits, chocolates.....1
- Gifts .....2
- Money.....3
- Services .....4
- Other .....5
- Specify.....
- Nothing .....9

**61. WHAT DO YOU PREFER AS A REMUNERATION/GIFT? (Check one ore more)**

- Flowers, spirits, chocolates.....1
- Gifts .....2
- Money.....3
- Services.....4
- Other .....5
- Specify.....
- Nothing .....9

**62. DO YOU AGREE THAT GENERALLY PATIENTS SHOULD BE OFFERED A CHOICE OF TREATMENT (e.g. birth options, etc.)?**

- Agree.....3
- Partly agree, partly disagree.....2
- Disagree .....1 [GO TO QUESTION 64]

**63. IN WHAT CIRCUMSTANCES WOULD YOU OFFER A CHOICE OF TREATMENT TO YOUR PATIENT?**

**64. IF YOUR PATIENT HAS A TERMINAL ILLNESS, WOULD YOU INFORM THEM?**

- Always ..... 5 [GO TO QUESTION 66]
- Often ..... 4 [GO TO QUESTION 66]
- Sometimes..... 3
- Rarely..... 2
- Next to never..... 1
- I have never been in such circumstances ..... 9 [GO TO QUESTION 66]

**65. IF YOUR PATIENT HAS A TERMINAL ILLNESS, ARE THERE CIRCUMSTANCES IN WHICH YOU WOULD NOT INFORM THEM?**

**66. HOW OFTEN ARE YOU DISSATISFIED WITH THE QUALITY OF MEDICAL CARE AT YOUR MEDICAL INSTITUTION?**

- Very often .....5
- Often .....4
- Sometimes.....3
- Rarely.....2
- Next to never.....1

**67. IF YOU ARE DISSATISFIED WITH THE QUALITY OF MEDICAL CARE AT YOUR INSTITUTION, WHO DO YOU DISCUSS IT WITH?**

Your family.....	1
Medical colleagues .....	2
Medical administrators .....	3
Medical associations .....	4
Trade unions .....	5
I do not discuss it with anyone.....	6
Other .....	9
Specify_____	
DK.....	88

**68. HOW OFTEN DO AVOIDABLE MISTAKES IN YOUR DEPARTMENT OCCUR?**

Very frequently .....	5
Frequently .....	4
Neither frequently, nor rarely .....	3
Rarely.....	2
Very rarely .....	1

**69. WHEN THERE HAS BEEN AN AVOIDABLE ERROR, WHAT IS THE REACTION OF YOUR COLLEAGUES?**

They try to “hush up” the affair .....	1
The case is discussed at the conference at the institution level .....	2
The case is discussed at the conference at the department level.....	3
The medical record is changed .....	4
Other .....	9
Specify_____	

**70. IF A MEDICAL PRACTITIONER’S MISTAKE HAS RESULTED IN A DEATH, WHO DO YOU THINK SHOULD BE RESPONSIBLE FOR DEALING WITH THIS?**

Colleagues.....	1
Medical institution administration .....	2
Medical association.....	3
Ministry of Health.....	4
Criminal court.....	5
Civil court .....	6
Other .....	7
Specify_____	
DK.....	8



71. WOULD YOU INFORM YOUR HEAD OF DEPARTMENT OF A MISTAKE YOU HAVE MADE?

- Always .....5
- Very often .....4
- Sometimes.....3
- Rarely.....2
- Next to never.....1

72. WHAT ETHICAL PROBLEMS DO YOU MOST OFTEN ENCOUNTER IN YOUR PRACTICE? (Please indicate)

VII. ALTERNATIVE MEDICINE

73. DO YOU EVER PRACTICE ALTERNATIVE MEDICINE?

- YES.....1
- NO .....2 [GO TO QUESTION 75]
- DK.....3 [GO TO QUESTION 75]

74. HOW OFTEN DO YOU PRACTICE ALTERNATIVE MEDICINE?

- Always .....5
- Very often .....4
- Sometimes.....3
- Rarely.....2
- Next to never.....1

75. DO YOUR MEDICAL COLLEAGUES EVER PRACTICE ALTERNATIVE MEDICINE?

- YES.....1
- NO .....2
- DK.....3

76. WOULD YOU REFER YOUR PATIENTS TO ALTERNATIVE MEDICAL PRACTITIONERS?

- YES.....1
- POSSIBLY .....2
- NO.....3 [GO TO QUESTION 78]
- DK.....4 [GO TO QUESTION 78]

**77. IN WHAT CIRCUMSTANCES WOULD YOU REFER YOUR PATIENTS TO ALTERNATIVE MEDICAL PRACTITIONERS?**

*Please indicate*

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**78. WHICH FORMS OF ALTERNATIVE MEDICINE SHOULD BE PROVIDED IN THE STATE SECTOR?**

- Acupuncture..... 1
  - Herbalism ..... 2
  - Apiotherapy ..... 3
  - Naturopathy ..... 4
  - Healing ..... 6
  - Aromatherapy ..... 7
  - Homoeopathy ..... 8
  - Hirudotherapy ..... 9
  - Other methods ..... 10
- 
- None ..... 11

**79. WHICH FORMS OF ALTERNATIVE MEDICINE SHOULD BE PROHIBITED?**

- Acupuncture..... 1
  - Herbalism ..... 2
  - Apiotherapy ..... 3
  - Naturopathy ..... 4
  - Healing ..... 6
  - Aromatherapy ..... 7
  - Homoeopathy ..... 8
  - Hirudotherapy ..... 9
  - Other methods ..... 10
- 
- None

**THANK YOU FOR TAKING THE TIME TO COMPLETE THE QUESTIONNAIRE!**